

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,
Plaintiff,

vs.

No. CJ-2017-816

PURDUE PHARMA L.P.;
PURDUE PHARMA, INC.;
THE PURDUE FREDERICK
COMPANY;
TEVA PHARMACEUTICALS
USA, INC.;
CEPHALON, INC.;
JOHNSON & JOHNSON;
JANSSEN PHARMACEUTICALS, INC.;
ORTHO-McNEIL-JANSSEN
PHARMACEUTICALS, INC., n/k/a
JANSSEN PHARMACEUTICALS, INC.;
JANSSEN PHARMACEUTICA,
INC., n/k/a JANSSEN
PHARMACEUTICALS, INC.;
ALLERGAN, PLC, f/k/a
ACTAVIS PLC, f/k/a ACTAVIS, INC.,
f/k/a WATSON PHARMACEUTICALS, INC.;
WATSON LABORATORIES, INC.;
ACTAVIS LLC; and
ACTAVIS PHARMA, INC.,
f/k/a WATSON PHARMA, INC.,

Defendants.

_____/

VIDEOTAPED DEPOSITION OF SCOTT FISHMAN, M.D.
Sacramento, California
Wednesday, February 27, 2019
Volume II

Reported by:
Carrie Pederson
CSR No. 4373, RMR, CRR

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WATSON LABORATORIES, INC.;
ACTAVIS LLC; and
ACTAVIS PHARMA, INC.,
f/k/a WATSON PHARMA, INC.,

Defendants.

Videotaped Deposition of SCOTT FISHMAN,
M.D., Volume II, taken on behalf of the defendants,
at 4860 Y Street, Sacramento, California, beginning
at 9:03 a.m. and ending at 4:48 p.m. on Wednesday,
February 27, 2019, before Carrie Pederson, Certified
Shorthand Reporter No. 4373.

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12 Videographer: John Macdonell

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1 Sacramento, California, Wednesday, February 27, 2019

2 9:03 a.m. - 4:48 p.m.

3
4 SCOTT FISHMAN, M.D.,
5 having been administered an oath, was examined and
6 testified as follows:

7 EXAMINATION

8 VIDEO OPERATOR: We're on the record.

9 It's 9:03 a.m. on February 27th, 2019.

10 This is the deposition of Scott Fishman,
11 Volume II.

12 We're here in the matter of State of
13 Oklahoma versus Purdue Pharma, et al.

14 We're located at 4860 Y Street in
15 Sacramento, California.

16 I'm John Macdonell, the videographer, with
17 Veritext. I'm not related to any party in this
18 action, nor am I a notary public or financially
19 interested.

20 If all parties agree to proceed, would
21 counsel please identify themselves for the record.

22 MR. ERCOLE: Sure. Brian Ercole from Morgan
23 Lewis on behalf of Teva defendants.

24 MR. EHSAN: Houman Ehsan, O'Melveny & Myers,
25 on behalf of Janssen and Johnson & Johnson

1 defendants.

2 MR. OXLEY: Bill Oxley from Dechert on
3 behalf of Purdue.

4 MS. CHURCHMAN: Brooke Churchman of Nix
5 Patterson on behalf of the State.

6 MR. BALDWIN: Lisa Baldwin for the State of
7 Oklahoma.

8 MR. ZAKRZEWSKI: Steve Zakrzewski for
9 Dr. Scott Fishman.

10 MR. ROBINSON: John Robinson, Gordon & Rees
11 Scully Mansukhani, on behalf of Dr. Fishman.

12 We need to dial in. We haven't dialed in
13 for the telephone participants.

14 MR. ERCOLE: Could we just go off the
15 record?

16 VIDEO OPERATOR: Sure. We're off the
17 record. It's 9:04.

18 (Recess).

19 VIDEO OPERATOR: Okay. We're back on the
20 record. It's 9:07 a.m.

21 We're just continuing the introductions on
22 the telephone.

23 MR. ZAKRZEWSKI: Okay. Those on the phone,
24 go ahead and make your appearance.

25 MR. SNYDER: Good morning. This is Ryan

1 Snyder from O'Melveny & Myers appearing on behalf of
2 Johnson & Johnson.

3 MS. REED: Good morning. This is Hannah
4 Reed from Gordon & Reese appearing on behalf of
5 Dr. Fishman.

6 MR. ERCOLE: Anyone else?

7 Okay. I think we're ready to begin.

8 BY MR. ERCOLE:

9 Q. Dr. Fishman, you realize you're still under
10 oath; correct?

11 A. I do.

12 Q. Okay. We talked yesterday about the
13 materials reference in Exhibit 1 of your deposition
14 which is your resume. Do you recall that?

15 A. I do.

16 Q. And there have been various objections that
17 were made by the State's counsel to certain
18 questions. Do you recall some of those?

19 A. Vaguely.

20 Q. Okay.

21 A. Trying to forget.

22 Q. Fair enough. Let me just ask a couple of
23 wrap-up questions which is did you independently
24 create the content of the articles, books,
25 presentations and other publications listed on your

1 resume that you authored or coauthored?

2 MS. BALWDIN: Object to form.

3 THE WITNESS: All of the work is independent
4 as far as my component of these works. Many of them
5 are collaborative efforts, so the parts that are my
6 work are my work independently.

7 BY MR. ERCOLE:

8 Q. And were the -- the work that you did
9 independently, was that free from the control of
10 pharmaceutical companies?

11 A. Yes.

12 MS. BALDWIN: Objection.

13 BY MR. ERCOLE:

14 Q. And the work that you did independently, was
15 that free from the influence of pharmaceutical
16 companies?

17 MS. BALDWIN: Objection. Leading.

18 THE WITNESS: Yes.

19 BY MR. ERCOLE:

20 Q. And you've heard the State has made certain
21 objections about -- called leading; right?

22 A. (Moves head up and down).

23 Q. Were you sued by the State in this case?

24 A. I was not.

25 Q. Okay. Do you have any interest in being

1 sued by the State in this case?

2 MR. ZAKRZEWSKI: Objection.

3 MS. BALDWIN: Objection.

4 MR. ZAKRZEWSKI: Form and foundation.

5 THE WITNESS: I don't.

6 BY MR. ERCOLE:

7 Q. Right. Fair to say you don't want to be
8 sued by the State in this case?

9 MR. ZAKRZEWSKI: Objection.

10 MS. BALDWIN: Objection.

11 THE WITNESS: Yes, I don't want to be sued.

12 BY MR. ERCOLE:

13 Q. And you're here pursuant to a subpoena?

14 A. I am.

15 Q. And is there anything that prevents you from
16 saying anything adverse to my clients here today?

17 A. Not that I can think of.

18 Q. Do my clients have any control over you?

19 A. Not that I can think of.

20 Q. In fact, you've settled with other
21 plaintiffs bringing other opioid cases across the
22 country; correct?

23 MR. ZAKRZEWSKI: Objection.

24 MS. BALDWIN: Objection.

25 THE WITNESS: Should I answer the question?

1 MR. ZAKRZEWSKI: Sure.

2 BY MR. ERCOLE:

3 Q. You can answer.

4 A. I think "settled" -- "settled" isn't a word
5 that I think is really what we did. We agreed that
6 they would drop the cases in a formal matter, and in
7 return, I agreed that I would continue to tell the
8 truth and be available to them if they want me to
9 tell them the truth about any experiences that I've
10 had.

11 Q. Fair enough. And the "them" that you're
12 referring to are plaintiffs?

13 A. Plaintiff.

14 Q. Plaintiffs' counsel?

15 A. Plaintiffs' counsel, yes.

16 Q. Okay.

17 MR. ZAKRZEWSKI: Well, objection. Form,
18 vague.

19 BY MR. ERCOLE:

20 Q. Okay. Let's mark this as Exhibit 32.

21 (Exhibit 32 marked)

22 THE WITNESS: Do I get one?

23 BY MR. ERCOLE:

24 Q. It's right here.

25 A. Oh, I'm sorry. Yes.

1 Q. Dr. Fishman, have you seen this document
2 before?

3 A. I believe I have. Yes, I have.

4 Q. And you've signed this document; is that
5 correct?

6 A. Yes.

7 Q. And it's a document that says "Settlement
8 Agreement" on the front of it?

9 A. Yes.

10 Q. And is it fair to say that this as a
11 Settlement Agreement that you reached with various
12 plaintiffs in opioid cases across the country?

13 MS. BALDWIN: Object to form.

14 MR. ZAKRZEWSKI: Objection. Form.

15 THE WITNESS: Yes.

16 BY MR. ERCOLE:

17 Q. Okay. And if you read the "Recitals"
18 language, it says -- if you go down, it says "Whereas
19 plaintiffs' firms have commenced legal actions
20 against several pharmaceutical companies, distributor
21 companies and individual physicians." Do you see
22 that?

23 A. Uh-huh.

24 MS. BALDWIN: Object to form.

25 THE WITNESS: Yes.

1 BY MR. ERCOLE:

2 Q. And so the cases in which you settled,
3 pharmaceutical companies were also named as
4 defendants in those cases too; correct?

5 A. Correct.

6 MR. ZAKRZEWSKI: Objection.

7 Question for you: Can I have a continuing
8 objection to your line of questioning as it relates
9 to the Settlement Agreement? Because I don't think
10 it bears any relevance to the Oklahoma matter as it
11 was never sued in the Oklahoma matter, and I just
12 want a continuing objection throughout the
13 questioning if you want to give it to me. Otherwise,
14 I'll object every question.

15 MS. BALDWIN: I'm going to join in asking
16 for that continuing objection.

17 MR. ERCOLE: So as has been the process here
18 in other depositions, there has not been an allowance
19 for continuing objections.

20 MR. ZAKRZEWSKI: Okay.

21 MR. ERCOLE: So feel free to pose any
22 objections.

23 MR. ZAKRZEWSKI: I only ask since I've heard
24 you ask for it, so you must have thought it was a
25 good idea. Apparently not, so I'll just object.

1 MR. EHSAN: Just for clarification, also
2 realizing that my understanding is you want to
3 perhaps use this transcript in other cases, so these
4 questions may go to alleviate other people's concerns
5 regarding the use of this transcript and others.

6 MR. ERCOLE: Feel free to object whenever
7 you want to.

8 MR. ZAKRZEWSKI: I understand the response
9 to the objection. It depends on where it's going to
10 be used and how it's going to be used and whether the
11 objection makes sense admittedly.

12 MR. EHSAN: Exactly.

13 BY MR. ERCOLE:

14 Q. And then if you go down, there's a "Whereas"
15 clause where it says "Whereas Dr. Fishman has
16 satisfied the terms of his April 9, 2018 Proffer
17 Agreement with plaintiffs' firms." Do you see that?

18 A. I do.

19 MS. BALDWIN: Object to form.

20 MR. ZAKRZEWSKI: Objection.

21 BY MR. ERCOLE:

22 Q. Did you enter into a Proffer Agreement with
23 plaintiffs' firms?

24 MS. BALDWIN: Object to form.

25 MR. ZAKRZEWSKI: Objection.

1 THE WITNESS: Yes.

2 BY MR. ERCOLE:

3 Q. Okay. And pursuant to that Proffer
4 Agreement, did you speak with plaintiffs' counsel in
5 those other cases?

6 MS. BALDWIN: Object to form.

7 THE WITNESS: Yes.

8 BY MR. ERCOLE:

9 Q. And if you turn to paragraph two where it
10 says "Settlement Stipulation" on page two of the
11 document. Do you see that?

12 A. I do.

13 Q. And then if you turn to little letter C. Do
14 you see that?

15 A. "Dr. Fishman agrees"?

16 Q. Yes.

17 A. Uh-huh.

18 Q. And it says "Dr. Fishman agrees that he will
19 cooperate with plaintiffs' firms in the pending and
20 anticipated litigation as follows." Did I read that
21 correctly?

22 A. That's correct.

23 MS. BALDWIN: Object to form.

24 MR. ZAKRZEWSKI: Objection.

25 (Discussion off the record)

1 THE WITNESS: It's hard to know if they will
2 or not and how much time they need, but --

3 MR. ERCOLE: And I'll do my best not to
4 speak over you, too, and allow for time.

5 THE WITNESS: Yeah.

6 BY MR. ERCOLE:

7 Q. And so in connection with this Settlement
8 Agreement with plaintiffs' counsel and plaintiffs in
9 other opioid cases, you agreed to cooperate with
10 those firms in connection with that pending and
11 anticipated litigation; right?

12 MS. BALDWIN: Object to form, and I'm just
13 going to state for the record I've never seen the
14 Settlement Agreement before. I don't know anything
15 about this Settlement Agreement. This has nothing to
16 do with the current case that's at issue in this
17 deposition.

18 MR. ERCOLE: Well, we'll disagree. Okay.

19 THE WITNESS: Can you restate your question?

20 BY MR. ERCOLE:

21 Q. Sure. In connection with this Settlement
22 Agreement with plaintiffs' counsel and plaintiffs in
23 other opioid cases, you agree to cooperate with those
24 firms in connection with that pending and anticipated
25 litigation; right?

1 A. I agree to --

2 MR. ZAKRZEWSKI: Objection.

3 THE WITNESS: I agree to continue to
4 cooperate by telling you the truth.

5 BY MR. ERCOLE:

6 Q. And, again, you met with -- how many times
7 did you meet with plaintiffs' counsel in those other
8 cases?

9 MR. ZAKRZEWSKI: Objection. Form.

10 MS. BALDWIN: Object to form.

11 THE WITNESS: Well, I'd have to say twice.

12 BY MR. ERCOLE:

13 Q. Do you recall when those times were?

14 A. Once was several years ago with -- prior to
15 being sued, and once was -- the second time was
16 about, I'd say, six, eight months ago.

17 Q. And the time you met six or eight months
18 ago, was that after a Proffer Agreement had been
19 entered into?

20 A. Yes.

21 MS. BALDWIN: Object to form.

22 THE WITNESS: Sorry. Yes.

23 BY MR. ERCOLE:

24 Q. And how long did you meet with plaintiffs'
25 counsel at that time?

1 A. About --

2 MS. BALDWIN: Object to form.

3 THE WITNESS: -- four or five hours.

4 BY MR. ERCOLE:

5 Q. Were any of the -- were any representatives
6 from any pharmaceutical companies there?

7 A. Not that I was aware of.

8 Q. Were any lawyers for any defendants there to
9 the best of your knowledge?

10 A. No.

11 MR. ZAKRZEWSKI: Objection.

12 MS. BALDWIN: Form.

13 THE WITNESS: Well, yes, they were.

14 BY MR. ERCOLE:

15 Q. Okay. Other than your counsel?

16 A. No.

17 MR. OXLEY: That's good.

18 BY MR. ERCOLE:

19 Q. And in connection with -- you said you met
20 with plaintiffs' counsel about six or eight months
21 ago for about four or five hours; is that fair to
22 say?

23 MS. BALDWIN: Object to form.

24 THE WITNESS: Yes.

25 BY MR. ERCOLE:

1 Q. And did they ask you questions?

2 MS. BALDWIN: Object to form.

3 THE WITNESS: Yes.

4 BY MR. ERCOLE:

5 Q. And did you provide answers to those
6 questions?

7 A. Yes.

8 MS. BALDWIN: Object to form.

9 BY MR. ERCOLE:

10 Q. And this Settlement Agreement, what's been
11 marked as Exhibit 32, reflects aspects of your
12 continued cooperation in connection with those
13 particular cases; correct?

14 MR. ZAKRZEWSKI: Objection.

15 MS. BALDWIN: Objection. Form.

16 MR. ZAKRZEWSKI: Form. You mean aspects of
17 what, at the time, he agreed he would do or things
18 that have happened?

19 MR. ERCOLE: So if you have an objection,
20 feel free to state it. I'll try and clarify a little
21 bit more.

22 BY MR. ERCOLE:

23 Q. The Settlement Agreement, what's been marked
24 as Exhibit 32, you looked at it; right? It says
25 "Dr. Fishman agrees that he will cooperate with

1 plaintiffs' firms in the pending and anticipated
2 litigation as follows." I read that correctly;
3 right?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: Yes.

6 BY MR. ERCOLE:

7 Q. And there are ongoing obligations in
8 connection with that cooperation provision; correct?

9 MR. ZAKRZEWSKI: Objection. Form.

10 MS. BALDWIN: Object to form.

11 MR. ZAKRZEWSKI: Vague, lacks foundation.

12 THE WITNESS: Actually, I think that the --
13 my belief is that there's actually no more ongoing
14 obligations, the timing of it has run out, but --

15 BY MR. ERCOLE:

16 Q. Okay. Why don't you take a look at that
17 paragraph 2(c) and then (v). So you if can look
18 at --

19 A. 2(c)(v)?

20 Q. Yeah.

21 A. Five?

22 MR. ZAKRZEWSKI: Five?

23 MR. ERCOLE: Yes.

24 BY MR. ERCOLE:

25 Q. And there, that provision is just an example

1 of when "Dr. Fishman agrees to cooperate with
2 plaintiffs' firms to provide sworn written proffers,
3 statements, affidavits and declarations to supplement
4 and reinforce Dr. Fishman's oral testimony." Do you
5 see that?

6 MS. BALDWIN: Object to form.

7 THE WITNESS: I do.

8 BY MR. ERCOLE:

9 Q. And that would be an ongoing commitment; is
10 that fair?

11 MS. BALDWIN: Object to form.

12 THE WITNESS: It's based on -- I'm sorry.
13 It's based on other commitments where the time has
14 run out on, so I would think that that ends as well,
15 but I'm just a doctor.

16 BY MR. ERCOLE:

17 Q. Okay. And as a result of providing that
18 information to plaintiffs' counsel in those other
19 cases, you were -- strike that.

20 In connection with agreeing to enter into
21 the Proffer Agreement and the Settlement Agreement,
22 the plaintiffs' counsel in those other cases agree to
23 release you or dismiss you from those cases; is that
24 fair to say?

25 A. Correct.

1 MS. BALDWIN: Object to form.

2 BY MR. ERCOLE:

3 Q. And you wanted to be dismissed from those
4 cases; is that fair to say?

5 MS. BALDWIN: Object to form.

6 THE WITNESS: Any which way we could.

7 BY MR. ERCOLE:

8 Q. Sure. And, in fact, you have been dismissed
9 from a number of cases as a result of entering into
10 this Settlement Agreement; is that fair to say?

11 MS. BALDWIN: Object to form.

12 THE WITNESS: Correct.

13 BY MR. ERCOLE:

14 Q. Yesterday, you mentioned a program where
15 Cephalon indicated that you had been paid for
16 providing some commentary, but in reality, you had
17 not been paid. Do you recall that?

18 MS. BALDWIN: Object to form.

19 THE WITNESS: I recall it, but the emphasis
20 on being paid isn't the right emphasis. It was that
21 it was -- that I -- that I had agreed I wasn't paid
22 and that it was only going to be used as a public
23 service announcement for public education, and they
24 used it on their media page. That, I know they did.

25 BY MR. ERCOLE:

1 Q. Uh-huh.

2 A. The media reported I had been paid. I
3 wasn't. I never confirmed that they had said that I
4 had been paid.

5 Q. Okay.

6 A. Just want to be clear about that.

7 Q. Can we mark this as Exhibit 33?

8 (Exhibit 33 marked)

9 BY MR. ERCOLE:

10 Q. Dr. Fishman, is this a letter that you
11 received from Teva USA on -- strike that.

12 Is this a letter from Teva USA to you?

13 A. Yes.

14 Q. And did you receive this letter?

15 A. Yes.

16 Q. And the public education program was titled
17 "When Good Medicines Become Bad Drugs." Is that fair
18 to say?

19 A. Yes.

20 Q. Okay. And if you read the last sentence in
21 the first paragraph, it says "Your taped commentary
22 for this program highlighted the risks associated
23 with inappropriate use of opioids." Did I read that
24 correctly?

25 A. You did.

1 MS. BALDWIN: Object to form.

2 BY MR. ERCOLE:

3 Q. And did your commentary do that?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: Yes, it did.

6 BY MR. ERCOLE:

7 Q. And do you recall what exactly you said in
8 connection with that --

9 A. I don't recall exactly what I said, but my
10 comments were about inappropriate use of opioids and
11 the effect on adolescents.

12 Q. And Teva asked for you to provide that
13 commentary; is that correct?

14 MS. BALDWIN: Object to form.

15 THE WITNESS: They asked me to participate
16 in this public service announcement program that they
17 were filming at a professional meeting somewhat on
18 the fly, and based on their request as a PSA and the
19 content that I felt particularly passionate about and
20 wanted to get the word out, I agreed.

21 BY MR. ERCOLE:

22 Q. Was there anything false or misleading in
23 that -- in any of the commentary that you provided
24 for that video?

25 MS. BALDWIN: Object to form.

1 MR. ZAKRZEWSKI: Objection.

2 THE WITNESS: No.

3 BY MR. ERCOLE:

4 Q. Was there anything false or misleading
5 associated with the program itself, at least with
6 respect to opioid prescribing?

7 MS. BALDWIN: Object to form.

8 MR. ZAKRZEWSKI: Object.

9 THE WITNESS: Certainly not as it relates to
10 my participation.

11 BY MR. ERCOLE:

12 Q. Well, sitting here today, can you identify
13 anything false or misleading about any other aspect
14 of that video other than the payment issue that
15 you've identified?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: So I think you just asked me
18 two different questions. One is -- all I know about
19 is what I said. I don't know if there's other
20 programming they created in addition, so I don't know
21 what full program they made around "When Good
22 Medicines Become Bad Drugs," but in terms of what I
23 provided, there was nothing false about that.

24 Secondly, what was problematic with the
25 outcome was that they had agreed to use the material

1 solely for consumer education public service
2 announcements, and they wound up putting it with my
3 name on their marketing website which I was then
4 called out for. I didn't know they had done it, by
5 the media as an example of how I was a shill for
6 pharmaceutical companies.

7 BY MR. ERCOLE:

8 Q. And do you believe you are a shill for
9 pharmaceutical companies?

10 MR. ZAKRZEWSKI: Objection. Form.

11 MS. BALDWIN: Objection to form.

12 THE WITNESS: I can assure you that I'm not
13 and have never been.

14 BY MR. ERCOLE:

15 Q. And do you find such allegations offensive?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: I find them offensive and
18 reacted immediately, and that's why I raised it with
19 Teva.

20 BY MR. ERCOLE:

21 Q. And then if you take a look at that last
22 paragraph -- well, second to last paragraph, it says
23 "Once you brought the error to our attention,
24 Cephalon immediately had the version of the video
25 pulled by PR Newswire and from the Cephalon corporate

1 site." Do you see that?

2 A. I do.

3 MS. BALDWIN: Object to the form.

4 BY MR. ERCOLE:

5 Q. Was that accurate?

6 MS. BALDWIN: Objection to the form.

7 THE WITNESS: Yes.

8 BY MR. ERCOLE:

9 Q. And it also goes on to say "We sent you an
10 email communication apologizing for distributing
11 video which incorrectly stated you were compensated."
12 Is that accurate?

13 A. Correct.

14 MS. BALDWIN: Object to form.

15 BY MR. ERCOLE:

16 Q. And it also goes on to say "We informed you
17 at that time that all video footage related to this
18 program would be removed." Did I read that
19 correctly?

20 A. Yes.

21 MS. BALDWIN: Object to form.

22 BY MR. ERCOLE:

23 Q. And did Cephalon remove all video footage of
24 that program?

25 A. To the best of my knowledge.

1 MS. BALDWIN: Object to form.

2 BY MR. ERCOLE:

3 Q. Okay. And so is it fair to say that at
4 least in this instance, with respect to Teva USA,
5 when you raised an issue with them concerning one of
6 their programming pieces, they immediately responded
7 and remedied any mistake or error associated with
8 that?

9 MS. BALDWIN: Object to form.

10 THE WITNESS: Well, they were quick to
11 reverse the wrongdoing. I don't know that they
12 remedied it, but, you know, the injury had already
13 occurred, and it's not something that's going to ever
14 leave the Internet, so --

15 BY MR. ERCOLE:

16 Q. Sir, at least with respect to the piece that
17 you provided, it was all about the risks associated
18 with inappropriate use of opioids; right?

19 MR. ZAKRZEWSKI: Objection to form.

20 MS. BALDWIN: Objection.

21 MR. ZAKRZEWSKI: Argumentative.

22 THE WITNESS: Yes.

23 BY MR. ERCOLE:

24 Q. Okay. And --

25 A. I'm just reacting to the word "remedy."

1 Q. Okay.

2 A. I mean they did what they could. I was
3 pleased that they were responsive. It didn't remedy
4 the problem that they caused --

5 Q. Okay.

6 A. -- for me.

7 Q. Fair enough. And the problem that you're
8 describing is a problem that impacted you; correct?

9 A. Correct.

10 MS. BALDWIN: Object to the form.

11 THE WITNESS: And created a false impression
12 of me in the media.

13 BY MR. ERCOLE:

14 Q. Okay. And that false impression was that
15 you were somehow a shill for pharmaceutical
16 companies?

17 A. That's how it was framed by, you know,
18 reporters.

19 MS. BALDWIN: Object to form.

20 BY MR. ERCOLE:

21 Q. And that's clearly not true; right?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: That is not true.

24 BY MR. ERCOLE:

25 Q. We talked yesterday a bit about the

1 responsibility of prescribers to make appropriate
2 decisions regarding opioids. Do you recall some of
3 that discussion?

4 A. I do.

5 Q. And is it fair to say that prescribers bear
6 responsibility for making an appropriate decision as
7 to whether or not to prescribe opioids?

8 MS. BALDWIN: Objection. Leading.

9 THE WITNESS: There are a lot of variables
10 that go into appropriate prescribing, and prescribers
11 bear a great deal of the responsibility in that
12 process.

13 BY MR. ERCOLE:

14 Q. And we'll mark this as Exhibit 34.

15 (Exhibit 34 marked)

16 BY MR. ERCOLE:

17 Q. Dr. Fishman, is this an article that you
18 wrote on prescription opioid -- strike that.

19 What is this document?

20 A. This is a manuscript that was published
21 regarding issues around reporting a forged
22 prescription of an opioid.

23 Q. And would you agree that forged
24 prescriptions of opioids are a problem?

25 MS. BALDWIN: Objection. Leading.

1 THE WITNESS: Yes.

2 BY MR. ERCOLE:

3 Q. Would you agree that forged prescriptions of
4 opioids are a significant problem?

5 MS. BALDWIN: Objection. Leading.

6 THE WITNESS: You know, I honestly don't
7 know how widespread a problem it is.

8 BY MR. ERCOLE:

9 Q. Okay.

10 A. But it's problematic for a number of
11 reasons. One is we don't really -- this article
12 relates to the fact that there's confusion about how
13 to handle the finding of a forged prescription
14 relative to HIPAA requirements.

15 Q. And if you'd take a look at page -- what's
16 marked as 941 on the bottom. It's page nine of that
17 document. Do you see that?

18 A. I do.

19 Q. And it says "Where does the responsibility
20 lie?" Do you see that?

21 A. Can you just orient me to it?

22 MS. BALDWIN: Object to form.

23 BY MR. ERCOLE:

24 Q. Yeah. Sure. It's at the bottom of the
25 document. It should be on page nine. Says "Where

1 does" --

2 A. Is this the same as -- it's my page nine.

3 Q. Yeah.

4 A. Oh, I'm sorry. Yeah. Right in front of me.
5 Sorry. I was looking in the body.

6 Q. I need my glasses to be able to see that
7 far.

8 A. Okay. Yes. "Where does the responsibility
9 lie?"

10 Q. Yeah. And it says -- this is in the article
11 that you coauthored, it says "The DEA and the Code of
12 Federal Regulations places responsibility on both the
13 practitioner and pharmacist for appropriate
14 prescribing and dispensing."

15 A. Right.

16 MS. BALDWIN: Object to form.

17 BY MR. ERCOLE:

18 Q. Is that an accurate statement, doctor?

19 MS. BALDWIN: Object to form.

20 THE WITNESS: Yes.

21 BY MR. ERCOLE:

22 Q. And you have a number of sort of -- looks
23 like citations in quotations afterwards to support
24 that proposition?

25 MS. BALDWIN: Object to form.

1 THE WITNESS: Well, and a quote from the
2 DEA.

3 BY MR. ERCOLE:

4 Q. Sure.

5 A. Yeah.

6 Q. Okay. And yesterday, we talked about a --
7 let me go back.

8 With respect to this particular article,
9 what's been now marked as Exhibit 34, was this an
10 article that you and your coauthors developed
11 independent of pharmaceutical company influence?

12 MS. BALDWIN: Object to form.

13 THE WITNESS: Yes.

14 BY MR. ERCOLE:

15 Q. We talked yesterday a lot about your book
16 "Responsible Opioid Prescribing, A Physician's
17 Guide." Do you recall that?

18 A. Yes.

19 MS. BALDWIN: Object to form.

20 THE WITNESS: Yes.

21 BY MR. ERCOLE:

22 Q. Is that the title of the book?

23 A. Yes.

24 Q. Okay. Could we mark this as Exhibit 35?

25 Thanks.

1 (Exhibit 35 marked)

2 BY MR. ERCOLE:

3 Q. Dr. Fishman, is this a copy of the book
4 "Responsible Opioid Prescribing" that you authored?

5 A. This appears to be one of the early proofs.

6 Q. Okay.

7 A. So not a final version of the book.

8 Q. Okay. And if you turn the page to the
9 second -- to the -- Responsible Opioid -- this the
10 third page of that document, it -- titled
11 "Responsible Opioid Prescribing, A Physician's
12 Guide." It's 514201.

13 A. Uh-huh.

14 Q. Do you see that?

15 A. I do.

16 Q. And it indicates that the book is
17 copyrighted 2007 by you?

18 A. Yes.

19 Q. Okay.

20 MS. BALDWIN: I'm just going to clarify for
21 the record that this excerpt that you -- is this an
22 entire copy of the book?

23 MR. ERCOLE: This is -- yeah, that's my
24 understanding, yes.

25 MS. BALDWIN: Okay. I'm just going to

1 represent for the record that this is a different
2 version of the book than I introduced into the record
3 yesterday.

4 MR. ERCOLE: Fine. I'll tell you what: Why
5 don't we -- with respect to the version, why don't we
6 pull that one out. Do you have a --

7 BY MR. ERCOLE:

8 Q. Turn to -- put that aside for a second, if
9 you don't mind, and then why don't you turn to
10 page -- Exhibit 26. And this is a copy -- this is
11 excerpts that the State -- of your book that the
12 State introduced yesterday. Do you recall that?

13 A. I do.

14 Q. Okay. If you turn to the -- it's not Bates
15 marked, but if you turn to the third page of that
16 document --

17 A. Uh-huh.

18 Q. -- it has a copyright of 2007. Do you see
19 that?

20 A. I do.

21 Q. Okay. And is that your copyright?

22 A. It is.

23 Q. Okay. And then the document goes on to list
24 the number of supporters of this particular book. Do
25 you see that?

1 A. I do.

2 Q. Okay. And the language in this book is your
3 language; right? You looked at the book, you
4 reviewed the root book, it's your independent
5 authorship for the book; correct?

6 MS. BALDWIN: Object to form and leading.

7 THE WITNESS: Yes.

8 BY MR. ERCOLE:

9 Q. Okay. And so some of the supporters
10 underneath the sort of category supporters, it says
11 "This book has been supported by a consortium of
12 organizations with a common interest in promoting
13 safe and effective pain management." Did I read that
14 correctly?

15 A. Yes.

16 Q. Okay. And so in your book, and this is the
17 2007 version at least, you were indicating that the
18 companies that helped support this book had a common
19 interest in promoting safe and effective pain
20 management; is that fair to say?

21 MS. BALDWIN: Object to form. Leading.

22 THE WITNESS: I fully believe that as a
23 foundation for writing the book and why
24 pharmaceutical companies would be a potential
25 purchaser of the book, because it would be in their

1 interest to support safe use of their drugs.

2 BY MR. ERCOLE:

3 Q. And when you say that, can you elaborate
4 upon that a little bit more?

5 A. You know, I felt like -- at the time, you
6 know, this book was written in 2006, well before the
7 media took hold of what was happening in terms of the
8 excessive use of opioids and the trends that were
9 starting to be seen with unintended overdose deaths.

10 This book was one of the first to actually
11 focus on the fact that we needed to apply greater
12 vigilance, we needed to take this drug group more
13 seriously and give it more -- give it more vigilance
14 in our using of these drugs and patients.

15 My belief was that pharmaceutical companies
16 would support that because they realized what I
17 realized at the time, which is we're heading down a
18 road, and I think I say this in this book, that we're
19 heading down a road where, if we continue down this
20 road, we're going to be prohibited from using this
21 class of drugs, so it's in everyone's interest that
22 we do it right, we do it safely so that there's --
23 the industry could protect its market and, you know,
24 I could protect patients from the harms that could
25 come from excessive use or inappropriate use of

1 drugs.

2 Q. And, in fact, for a number of years prior to
3 the publication of this book, you had been giving CME
4 presentations about responsible opioid prescribing
5 that were sponsored indirectly by pharmaceutical
6 companies; is that fair to say?

7 MS. BALDWIN: Objection. Leading.

8 THE WITNESS: Mostly indirectly, but yes.
9 Yes.

10 BY MR. ERCOLE:

11 Q. And in connection with the supporters of
12 this book, there are a number of different companies
13 that are listed; is that correct?

14 A. Uh-huh.

15 Q. And Cephalon is identified as a supporter
16 that had an interest in promoting safe and effective
17 pain management?

18 MS. BALDWIN: Object to form.

19 BY MR. ERCOLE:

20 Q. Is that correct?

21 A. Yes.

22 Q. Okay. And --

23 A. As stated here.

24 Q. Yeah. And Purdue Pharma LP is also
25 identified there?

1 A. It is.

2 Q. Okay. And in addition, there are other
3 companies listed there that supported your book as
4 well too; right?

5 A. There's some that supported the CME
6 activity.

7 Q. And with respect to some of the other
8 entities, it looks like they're -- the American
9 Cancer Society is listed.

10 A. Correct.

11 Q. What is the American Cancer Society?

12 A. American Cancer Society is a nonprofit -- a
13 large nonprofit organization interested in advancing
14 the care of patients with cancer.

15 Q. And they also supported the Responsible
16 Opioid Prescribing book that you authored?

17 MS. BALDWIN: Objection. Leading.

18 THE WITNESS: I believe they supported this
19 book because responsible opioid prescribing is a
20 important element of optimal cancer care.

21 BY MR. ERCOLE:

22 Q. Sure. And it looks like there's -- one of
23 the other supporters was the Candlelighters Childhood
24 Cancer Foundation. What is that? Do you know?

25 A. I don't know.

1 Q. There's another listing here for the
2 International Association for Pain and Chemical
3 Dependency. Do you see that?

4 A. Yes, I do.

5 Q. Do you know what that entity does?

6 A. Again, that's a -- to my knowledge, that's
7 an international professional organization that was
8 dealing with issues around pain management and
9 addiction, chemical dependency.

10 Q. And there's also a reference here to the
11 Lance Armstrong Foundation.

12 A. Uh-huh.

13 Q. Do you know what the Lance Armstrong
14 Foundation is?

15 A. Again, a nonprofit that was interested -- I
16 believe their focus was largely in the area of
17 wellness. As you may know, Lance Armstrong had
18 cancer, and there was interest in cancer pain
19 management as well, and I think that's where the
20 connection came. I think they were -- they
21 participated in conjunction with the American Cancer
22 Society.

23 Q. So is it fair to say, then, that this book
24 that you authored, Responsible Opioid Prescribing,
25 was supported by a number of organizations apart from

1 the pharmaceutical industry?

2 MS. BALDWIN: Objection. Leading.

3 THE WITNESS: I think the listing of, you
4 know, partners suggests this was a very broad
5 coalition, including the Department of Health and
6 Human Services, represented by the Substance Use and
7 Mental Health Services Administration, which, you
8 know, is directly entrusted with dealing with health
9 issues around addiction in America.

10 BY MR. ERCOLE:

11 Q. And you mentioned yesterday that there were
12 drafts of the book that you circulated to various
13 entities; is that correct?

14 A. Individuals.

15 Q. Okay. And were some of those individuals
16 associated with the federal government?

17 A. Yes.

18 Q. Can you sort of describe what you did there
19 a little bit?

20 A. Well, you know, there are people that I
21 worked with in the DEA and the Office of the National
22 Job Control Strategy, the White House drug czar's
23 office and elsewhere, who were respected colleagues
24 in this area, of what was happening with drug abuse,
25 and I asked them for advice on how to characterize or

1 how I characterize the ensuing epidemic.

2 Again, when this was written, the word
3 "epidemic" was not in the national vernacular. Now
4 we look back, and clearly it was happening at this
5 time, but nobody was talking about it. So, you know,
6 I asked -- I can't even remember who -- I know one
7 person is Chris Jones, who's been a very prominent
8 participant in the federal oversight of the
9 prescription drug abuse problem in America, and he
10 was at the ONDCP at the time, then went to CDC, was
11 at HSS, and I actually think -- I think he's actually
12 back at ONDCP now, but probably one of the most --
13 maybe, in my opinion, the most informed person in the
14 country on what's happening with the opioid crisis
15 and the opioid epidemic.

16 You know, he was someone who looked at the
17 book. I think he's actually listed in this next
18 edition by name. But there was someone who was the
19 undersecretary of -- or the associate director of the
20 ONDCP, and I don't remember her name. She was a
21 psychiatrist from Harvard, and she reviewed the book,
22 this book for us to give us feedback.

23 And then there are other colleagues in the
24 field, you know, like David Haddox that I mentioned
25 from Purdue. Again, I didn't send him the book

1 because -- or I didn't send him parts of the book,
2 and I didn't expect him to do a line review of the
3 book. I just wanted to get his reaction and to, just
4 like everyone else, just get a sense of whether what
5 was being said would be viewed as controversial from
6 people on one side or the other. So I sent it out,
7 you know, widely once it was pretty much complete.

8 Q. Right. And, for instance, using --

9 MS. BALDWIN: I'm going to object to that as
10 nonresponsive.

11 BY MR. ERCOLE:

12 Q. Okay. You mentioned Chris Jones; right?

13 A. (Moves head up and down).

14 Q. When you sent the, I guess -- was it a
15 manuscript you would have sent out?

16 A. I don't remember if I sent him a manuscript.
17 I sent him just passages.

18 Q. Okay.

19 A. I don't remember. Or sat down with him and
20 discussed it in meetings.

21 Q. Did he ever come to you and say, "Hey, this
22 book is riddled with misrepresentations" in some way,
23 shape or form?

24 MS. BALDWIN: Objection. Leading.

25 THE WITNESS: No. He was kind to me in that

1 he was willing to review the interpretations of data
2 that could be looked at a lot of different ways, and,
3 again, the first time I met Chris, it wasn't clear
4 what kind of catastrophe we were in. Later on, it
5 was much clearer, and he was very helpful in really
6 stating the data for the second edition where -- you
7 know, I would argue the difference between the first
8 edition and the second edition is that we had the
9 data for the second edition.

10 Really, the premise of the book didn't
11 change and the foundation positions of the book
12 didn't change. What changed is we had hard data that
13 we didn't have in 2006 to really base our beliefs on.

14 So he was much -- he was very, very helpful
15 on the second edition, and I think we name him in the
16 book as such. But, you know, he, you know, kind of
17 just gave me reactions. I don't know that I really
18 gave anybody the opportunity to be a editor of the
19 book. So --

20 BY MR. ERCOLE:

21 Q. And you controlled that editing process?

22 A. I did.

23 MS. BALDWIN: Object to form. Leading.

24 BY MR. ERCOLE:

25 Q. And if you turn to Exhibit 35, which

1 actually --

2 A. We're back to this?

3 Q. Yes. Which actually has the text of the
4 book in there. I don't want to walk through every
5 paragraph with you, but if you can just turn to the
6 "Forward" page, it looks like page one. Do you see
7 that?

8 A. Yeah. I just want to say that, again, you
9 have a -- this is a -- what you produced was
10 uncorrected page proofs, and I believe, in the first
11 edition of the book, the forward was by Regina
12 Benjamin who -- Regina Benjamin, Dr. Regina Benjamin
13 who would go on to become the Surgeon General.

14 Q. Okay. So you can put Exhibit 35 -- then put
15 that aside.

16 With respect to the book itself, does the
17 book discuss the risks associated with the use and
18 prescribing of opioids?

19 A. Yes.

20 Q. Okay. And what does it say about those
21 risks?

22 A. That -- again, I'm not sure how much depth
23 you want me to go into that because that's really
24 the -- that's the main body of the book, that there
25 are substantial risks that need to be understood and

1 considered when these drugs are prescribed, and they
2 need to be considered, not just when they're
3 prescribed, but when they're renewed, refilled and
4 doses are changed.

5 Q. And do you describe in the book what those
6 risks are?

7 A. Yes.

8 Q. And what are some of those risks?

9 A. Well, the risk that I think is most feared
10 is respiratory depression, but there are other risks
11 around addiction; dependence, constipation, sedation,
12 other substantial -- endocrine effects, etc.

13 Q. And does your book lay out all those risks
14 for any physician who was willing to read it?

15 MS. BALDWIN: Object to form.

16 THE WITNESS: The book was intended as a
17 very readable primer, so -- and I think it says there
18 that it was not intended as a exhaustive review of
19 everything about opioids and opioid prescribing. It
20 wouldn't be possible to do that, particularly in
21 this -- in such a -- you know, a handbook.

22 The hope was that this would be enough to
23 convince prescribers that there's a lot they need to
24 know about prescribing and get them started in a very
25 readable format that we felt most primary care

1 doctors and other clinicians could read in an
2 evening.

3 BY MR. ERCOLE:

4 Q. And does your book lay out various steps
5 doctors can take to prescribe opioids responsibly?

6 A. It does.

7 MS. BALDWIN: Object to form. Leading.

8 BY MR. ERCOLE:

9 Q. Okay. And is one of those steps screening
10 patients for addiction?

11 A. Yes.

12 MS. BALDWIN: Objection to form. Leading.

13 BY MR. ERCOLE:

14 Q. And can the failure to screen patients for
15 addiction result in inappropriate opioid prescribing?

16 MS. BALDWIN: Object to form. Leading.

17 THE WITNESS: Yes.

18 BY MR. ERCOLE:

19 Q. Is another one of those steps that doctors
20 can take making sure to spend an appropriate amount
21 of time with each particular patient before writing
22 an opioid prescription?

23 MS. BALDWIN: Object to form. Leading.

24 THE WITNESS: I would say that the
25 expectation is that histories and physical exams

1 would be obtained, and they would take time.

2 BY MR. ERCOLE:

3 Q. And is that the expectation before writing
4 an opioid prescription?

5 A. Correct.

6 MS. BALDWIN: Object to form.

7 BY MR. ERCOLE:

8 Q. And the failure to take the time to do
9 histories and physical examinations by a physician
10 could result in an inappropriate prescription of
11 opioids; is that correct?

12 MS. BALDWIN: Object to form. Leading.

13 THE WITNESS: It could be -- it could lead
14 to inappropriate prescribing, and it would be seen as
15 practice beneath the standard of care.

16 BY MR. ERCOLE:

17 Q. And when you say "take a" -- when you
18 reference the word -- the term "histories," what do
19 you mean by that?

20 A. Acquiring the information about the
21 patient's past medical experiences and their illness,
22 their record of illnesses, their medical,
23 psychological, social information that would be
24 necessary to have a sense of who you're treating,
25 what they have and what would be safe to give them,

1 you know, in the face of their complaints.

2 Q. And is that essential for physicians to do
3 before writing an opioid prescription?

4 A. It is.

5 MS. BALDWIN: Object to form. Leading.

6 BY MR. ERCOLE:

7 Q. And the failure to do so may result in an
8 inappropriate prescription; is that fair to say?

9 MS. BALDWIN: Object to form. Leading.

10 THE WITNESS: It may.

11 BY MR. ERCOLE:

12 Q. And it may not too; correct?

13 MS. BALDWIN: Object to form. Leading.

14 THE WITNESS: Yes.

15 BY MR. ERCOLE:

16 Q. Another step you identified for
17 appropriate -- strike that.

18 Is coming up with a treatment plan for a
19 patient another step you identify for physicians to
20 prescribe opioids responsibly?

21 MS. BALDWIN: Object to form. Leading.

22 THE WITNESS: Yes.

23 BY MR. ERCOLE:

24 Q. And what does that mean when coming up with
25 a treatment plan?

1 A. It means that rather than just reacting with
2 a treatment, that clinicians need to think about a
3 plan for how they're going to use a treatment, which
4 involves understanding why they're using it, what the
5 outcome of the treatment would be that would
6 designate that the treatment is successful or a
7 failure, and how the treatment would be delivered,
8 either in one step or incrementally, etc., and how
9 the treatment would be discontinued if there was a
10 problem.

11 Q. And would the failure to come up with a
12 treatment plan for -- strike that.

13 Would a physician's failure to come up with
14 a treatment plan for a particular patient before
15 writing an opioid prescription fall beneath the
16 appropriate standard of care in your view?

17 MS. BALDWIN: Object to the form. Leading.

18 THE WITNESS: Not in and of itself, but it
19 would be -- potentially be part of that determination
20 because it would be an expected part of good care,
21 but, again, it's a part.

22 BY MR. ERCOLE:

23 Q. How about was another step you identify for
24 physicians to prescribe opioids appropriately making
25 sure to listen to what the patient has to say about

1 his or her pain?

2 MS. BALDWIN: Object to form. Leading.

3 THE WITNESS: Yes.

4 BY MR. ERCOLE:

5 Q. And is it fair to say that the failure to do
6 so could result in an inappropriate prescription of
7 opioids being written by that particular physician?

8 MS. BALDWIN: Object to form. Leading.

9 THE WITNESS: It could.

10 BY MR. ERCOLE:

11 Q. How about was another step that you identify
12 in your book for appropriate opioid prescribing
13 making sure that physicians monitor their patients
14 after writing an opioid prescription?

15 MS. BALDWIN: Object to form. Leading.

16 THE WITNESS: Yes.

17 BY MR. ERCOLE:

18 Q. And why is that important?

19 A. It's important to monitor your patients
20 because if adversity comes and you're not --
21 adversity occurs and you're not monitoring the
22 patients, you may miss it, and the patients may be
23 injured.

24 Q. And when you say "adversity," what are you
25 referring to there?

1 A. Adverse effects from the treatment, you
2 know.

3 Q. And can the failure to monitor a patient
4 after writing an opioid prescription lead to the
5 inappropriate prescribing of subsequent opioid
6 prescriptions for that patient?

7 MS. BALDWIN: Object to form. Leading.

8 THE WITNESS: Yes.

9 BY MR. ERCOLE:

10 Q. These are all the -- all the things we're
11 discussing are all steps that physicians can take to
12 ensure opioid prescribing, proper opioid prescribing;
13 is that fair to say?

14 MS. BALDWIN: Object to form. Leading.

15 THE WITNESS: They're steps that are
16 described in the book as expected parts of care of
17 patients who are responsibly prescribed opioids.

18 BY MR. ERCOLE:

19 Q. And when you say "expected parts of care,"
20 what are you referring to there?

21 A. Well, you know, again, this book was written
22 for physicians in response to the Federation of State
23 Medical Board's model policy on opioid prescribing
24 which is a policy that wasn't intended for
25 physicians. It's intended for medical boards as

1 guidance in reviewing the practice of physicians if
2 their practice is called into question.

3 So one of the main -- a main premise of this
4 book is that physicians should know -- or prescribers
5 should know what's expected of them if they are
6 investigated, and when I say "expect," you know, this
7 would be expected, it would be expected by a medical
8 board, or I think investigator said if they look at
9 their practice and they see that they are prescribing
10 opioids, that, for instance, they have a plan for how
11 they're using the opioids that is fairly transparent
12 in the patient's documentation and they have a --
13 there's a record of following up with their patients
14 to see how they're doing, whether they're doing well
15 or doing poorly, particularly if you're going to be
16 changing the dose or refilling those opioids.

17 Q. And you reference in here the model policy
18 on -- strike that.

19 In your last answer, you reference the model
20 policy on opioid prescribing.

21 A. Yes.

22 Q. And who authored that policy?

23 A. It was a policy that was created by the
24 Federation of State Medical Boards and, I think,
25 signed off by their full congress of representatives

1 from state medical boards across the country, I think
2 all of the state medical boards in the United States.

3 Q. To the best of your knowledge, did
4 pharmaceutical companies control the content of that
5 policy by the Federal and State Medical Board?

6 MS. BALDWIN: Object to form.

7 THE WITNESS: The Federation of State
8 Medical Boards?

9 BY MR. ERCOLE:

10 Q. Yes.

11 A. To my knowledge, the pharmaceutical
12 companies did not control, but they did contribute to
13 the funding of several of the older editions of the
14 model policy or the versions of the model policy.

15 Q. And so in your -- if I refer to "the
16 federation," can we agree that I'm referring to the
17 FSMB?

18 A. Yes.

19 Q. Okay. You mentioned that the FSMB received
20 funding from pharmaceutical companies; is that
21 correct?

22 A. I believe so.

23 MS. BALDWIN: Object to form.

24 BY MR. ERCOLE:

25 Q. Do you know one way or the other?

1 A. Again, I don't know with certainty what they
2 received or what it was for, but I'm pretty sure that
3 they received funding from pharmaceutical companies
4 to support the process of developing their model
5 policy. I don't think they have done that recently
6 but in the past.

7 Q. And the model -- when was the first model
8 policy?

9 A. I want to say in the late 1990's.

10 Q. Okay. And did the -- to the best of your
11 knowledge, did the FSMB or the federation develop
12 that policy -- strike that.

13 Did the FSMB develop that policy
14 content-wise independently from pharmaceutical
15 companies?

16 MS. BALDWIN: Object to form. Leading.

17 THE WITNESS: I don't know. I wasn't part
18 of that first iteration of the policy.

19 BY MR. ERCOLE:

20 Q. Sitting here today, do you have any
21 knowledge that any pharmaceutical company had any
22 influence on the development -- strike that.

23 Sitting here today, do you have any
24 knowledge of any influence that pharmaceutical
25 companies had on the development of the content of

1 that first policy?

2 MS. BALDWIN: Object to form.

3 THE WITNESS: No.

4 BY MR. ERCOLE:

5 Q. Okay. Was there -- we'll get into the
6 federation in a little bit, but with respect to the
7 Responsible Opioid Prescribing book that you
8 authored, let's mark this as Exhibit 36.

9 (Exhibit 36 marked)

10 BY MR. ERCOLE:

11 Q. Dr. Fishman, this is a document titled
12 "Unrestricted Educational Grant Agreement." Do you
13 see that?

14 A. I do.

15 Q. And it's an agreement between Cephalon and
16 the Federation of State Medical Boards
17 Research & Education Foundation? Am I reading that
18 correctly?

19 A. Right. You are.

20 Q. Okay. And what was the Federation of State
21 Medical Boards Research & Education Foundation to the
22 best of your knowledge?

23 A. You know, I think --

24 MS. BALDWIN: Object to form.

25 THE WITNESS: I'm sorry. I think it's a

1 nonprofit arm of the federation to do educational
2 work, I believe.

3 BY MR. ERCOLE:

4 Q. And we talked about the federation. What
5 exactly was or what exactly is the federation?

6 A. Again, I'm not a member of the federation.
7 My sense of the federation is that it's a -- truly a
8 federation of the state medical boards in the United
9 States with the House of Delegates that has a system
10 of representation for all the state medical boards to
11 support the issues that they have to deal with in a
12 collective manner rather than with each existing
13 individually.

14 Q. And does the federation consist of
15 independent medical professionals to the best of your
16 knowledge?

17 MS. BALDWIN: Objection. Leading.

18 THE WITNESS: They're independent medical
19 professionals who work with state medical boards and
20 are part of the federation, but I believe that other
21 than the staff of the federation or the FSMB, the
22 individual physicians are clinicians who are
23 associated with their state medical boards and then
24 seek to have a role in the federation --

25 BY MR. ERCOLE:

1 Q. Okay.

2 A. -- representing a specific statement, I
3 believe.

4 Q. Thank you for that clarification. If you
5 take a look at this agreement, it states in the first
6 paragraph "Educational grant of the amount of
7 \$100,000 to support the dissemination of the book
8 Responsible Opioid Prescribing, a Physician's Guide."
9 Did I read that correctly?

10 A. Yes.

11 Q. Okay. And can you go to the first -- and
12 the Responsible Opioid Prescribing, a Physician's
13 Guide is your book; correct?

14 A. Yes.

15 Q. Okay. And if you go to paragraph one,
16 "Statement of Purpose," it says "Cephalon and the
17 organization agree that any and all materials
18 developed for this program are for educational
19 purposes and not to promote any Cephalon products,
20 and that any discussion of Cephalon products that may
21 occur in relation to this grant will be objective and
22 balanced." Do you see that?

23 A. I do.

24 MS. BALDWIN: Object to form.

25 BY MR. ERCOLE:

1 Q. And to the best of your knowledge, does this
2 agreement, then, reflect the fact that any materials
3 developed in connection with this grant were not
4 allowed to promote any Cephalon products?

5 MS. BALDWIN: Object to form.

6 THE WITNESS: I would go further and say
7 that this grant was to support dissemination of the
8 book, not the content of the book or anything about
9 what was in the book. So I don't think this
10 product -- this project in any way was anything that
11 touched me.

12 BY MR. ERCOLE:

13 Q. Okay. And your book Responsible Opioid
14 Prescribing didn't mention any Cephalon products; is
15 that fair to say?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: You know, again, I don't
18 remember. I don't think so, and I don't even
19 remember exactly what Cephalon made at the time. I
20 believe it was -- and it may have been the rapid
21 onset opioids which weren't a part of the discussion
22 of Responsible Opioid Prescribing.

23 BY MR. ERCOLE:

24 Q. And when you say weren't a part of that
25 discussion, why do you say that?

1 A. Because Responsible Opioid Prescribing was
2 really about chronic pain and that those drugs,
3 particularly at the time, were really limited to the
4 use in cancer patients who needed really urgent onset
5 analgesia.

6 Q. And so you would distinguish, then, sort of
7 rapid onset opioids from long-acting opioids in that
8 sense?

9 MS. BALDWIN: Object to form.

10 THE WITNESS: I would distinguish them
11 clearly, and I would also distinguish that their use
12 was, at this time, in my mind, controversial, and I
13 was concerned about them and didn't use them. I
14 didn't feel that there was a role for them in chronic
15 pain.

16 BY MR. ERCOLE:

17 Q. And that was an independent medical
18 determination that you made; correct?

19 A. Correct.

20 Q. And when you say "them," you mean --

21 A. These rapid onset, usually transmucosal
22 fentanyl products.

23 Q. Okay. And if you turn to paragraph eight of
24 this particular document, do you see where it says
25 "Focus of the Materials"?

1 A. Uh-huh.

2 Q. "The organization is to create educational
3 materials that are free from commercial influence or
4 bias." Did I read that correctly?

5 A. Yes.

6 MS. BALDWIN: Form.

7 BY MR. ERCOLE:

8 Q. And that was, at least according to this
9 document, a paragraph in the educational grant that
10 was given to the federation in connection with the
11 dissemination of your book?

12 MS. BALDWIN: Object to the form.

13 THE WITNESS: Correct.

14 BY MR. ERCOLE:

15 Q. And just with respect to grants generally,
16 have you -- strike that.

17 With respect to grants sought by the
18 federation concerning your book, were you involved
19 with preparing any of those requests?

20 A. Not that I remember.

21 Q. Okay.

22 A. In fact, I'm not a signatory to this. I
23 don't know that I was involved in this.

24 Q. Sure. And if you look at page four of this
25 document, is it fair to say that at least in

1 connection with this document, that the federation
2 was affirmatively reaching out to Cephalon to request
3 a grant for this project?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: Yes. I think they were
6 looking to find funding to give a book that medical
7 boards wanted, but the medical boards didn't have
8 funding -- don't have the funding for these kinds of
9 programs.

10 MR. ERCOLE: Could we mark this as
11 Exhibit 37?

12 (Exhibit 37 marked)

13 BY MR. ERCOLE:

14 Q. Dr. Fishman, do you know, have you seen the
15 document that's been marked as Exhibit 37 before?

16 A. I have.

17 Q. Okay. And what is that document?

18 A. It's the "Second Edition, Revised and
19 Expanded, of Responsible Opioid Prescribing,
20 Clinician's Guide."

21 Q. And were you responsible for the content of
22 this book?

23 A. Yes.

24 MS. BALDWIN: Object to form. Leading.

25 BY MR. ERCOLE:

1 Q. And if you'd turn to the second page of this
2 document, at least -- let's just use the Bates
3 number, 6904 on the bottom.

4 A. Yes.

5 Q. And has a copyright of 2012. Do you see
6 that at the top?

7 A. I do.

8 Q. And is that your copyright?

9 A. Yes.

10 Q. Okay. And -- do you need to take a break,
11 sir?

12 A. No. I'm sorry. I'm just getting a text on
13 patients.

14 Q. Okay.

15 A. Sorry about that.

16 Q. I'm happy to take a break for you.

17 A. No. I'm fine.

18 Q. Okay.

19 A. Just turning it off.

20 Q. Thank you. So there's also a list of
21 supporters of the second edition of this book. Do
22 you see that?

23 A. Yes.

24 Q. Okay. And, again, this is in 2012. There's
25 a statement right upfront that "This book has been

1 supported by a consortium of organizations with a
2 common interest in promoting safe and effective pain
3 management." Do you see that?

4 A. I do.

5 MS. BALDWIN: Object to form.

6 BY MR. ERCOLE:

7 Q. Okay. And Cephalon is listed as one of
8 those supporters who was interested in promoting safe
9 and effective pain management?

10 MS. BALDWIN: Object to form. Leading.

11 THE WITNESS: Yes.

12 BY MR. ERCOLE:

13 Q. Okay. But there are also a number of other
14 companies listed here again too; correct?

15 MS. BALDWIN: Object to form. Leading.

16 THE WITNESS: Correct.

17 BY MR. ERCOLE:

18 Q. And many of those companies are not opioid
19 manufacturers; is that fair to say?

20 MS. BALDWIN: Object to form. Leading.

21 THE WITNESS: Yes.

22 BY MR. ERCOLE:

23 Q. And with respect to the second edition of
24 your book, did you also send sort of a -- you know,
25 whether a manuscript or a draft of the book, to

1 individuals affiliated with the federal government
2 before its publication?

3 A. Yes.

4 Q. And who did you send those two?

5 A. You know, I don't remember exactly, but, you
6 know, again, Chris Jones was helpful in this edition.
7 There's a different administration. We'd gone from
8 the George W. Bush Administration to the Obama
9 Administration at this point.

10 Yeah, I don't remember the names of -- I
11 don't recall the names of people, but, you know, I
12 sought input on -- I was less concerned about the
13 reactions to the positions because the positions
14 really hadn't changed. What changed in this is
15 the -- largely the data, and I wanted to make sure I
16 was representing the data correctly because it's very
17 complicated.

18 Q. The data is?

19 A. Yeah.

20 Q. And in the second edition of the book, this
21 is going to sound overly simplistic, but do you also
22 outline steps that providers can take to ensure
23 appropriate prescribing of opioids?

24 MS. BALDWIN: Object to form. Leading.

25 THE WITNESS: Yes.

1 BY MR. ERCOLE:

2 Q. And do you outline the risks associated with
3 prescribing of opioids in this book?

4 MS. BALDWIN: Object to form. Leading.

5 THE WITNESS: Yes.

6 BY MR. ERCOLE:

7 Q. And do you outline the risks associated with
8 the prescribing of opioids for long-term chronic
9 pain?

10 MS. BALDWIN: Object to form. Leading.

11 THE WITNESS: Yes.

12 BY MR. ERCOLE:

13 Q. Okay. And is it fair to say that if a
14 prescriber was to read either your -- the first
15 edition of this book in 2007 or the second edition of
16 this book in 2012, he or she would be informed about
17 the risks associated with prescribing opioids?

18 MS. BALDWIN: Object to form. Leading.

19 MR. ZAKRZEWSKI: Objection. Form.

20 You can answer.

21 THE WITNESS: My intent was that anyone who
22 read this book would hear the message, "Be careful
23 with these drugs," and here is a lot of information
24 that would back up why you'd need to be careful
25 including the risks.

1 BY MR. ERCOLE:

2 Q. Do you know whether the Responsible Opioid
3 Prescribing book is still in print?

4 A. I don't believe it is.

5 Q. Okay. Was there ever another edition of
6 that book?

7 A. Yes.

8 Q. And so there have been three editions?

9 A. Correct.

10 Q. And with respect to all three of those
11 editions, did you independently create the content of
12 those editions?

13 MS. BALDWIN: Object to form.

14 THE WITNESS: I independently oversaw the
15 content. Some of it was -- for instance, the third
16 edition -- really, the only difference between the
17 second edition and that third one, which is just --
18 it's a second edition expanded or some other
19 terminology -- is that it included guidelines that
20 didn't exist at the time that this -- the second
21 edition was published, so it's a much more robust
22 appendix of materials that didn't exist at the time
23 that the second edition was published but I felt were
24 absolutely crucial for readers to have in this
25 compendium.

1 BY MR. ERCOLE:

2 Q. And did all of your books include an
3 appendix?

4 A. They did.

5 Q. And what did the appendix have for those
6 books?

7 MR. ZAKRZEWSKI: Objection.

8 You can answer.

9 THE WITNESS: The appendix were resource
10 materials that would -- like, for instance, they
11 had -- the FSMB model policy was part of the
12 appendix, and I think it had been updated between the
13 first book and the second book and other, you know,
14 general resources that would be helpful. Again, it
15 wasn't an exhaustive volume.

16 BY MR. ERCOLE:

17 Q. And you've referred to -- so we've been
18 talking about the federation or the FSMB. We spoke
19 about a -- strike that.

20 In 1998, did the FSMB publish model
21 guidelines?

22 A. In 1998?

23 Q. Yes.

24 A. I believe so. I suspect that was the first
25 edition of the guidelines.

1 Q. Okay. And were you involved in that process
2 at all?

3 A. No.

4 Q. And at some point, were those guidelines
5 updated to a policy?

6 A. Well, you know, I don't know when it was --
7 the name was created as the model policy. I thought
8 it was in '98, but it may have been in 2004. I was
9 involved with the creation of the 2004 model policy.
10 I was a member of a large committee.

11 Q. In connection with the 2004 model policy,
12 are you aware of -- strike that.

13 With respect to the 2004 model policy, did
14 pharmaceutical companies control the content of that
15 policy?

16 MS. BALDWIN: Object to the form. Leading.

17 THE WITNESS: I don't believe they
18 controlled the content, but, again, there was -- you
19 know, David Haddox was part of that process, and I
20 believe he was at Purdue at that time, so it was a
21 point of contention, I suppose, that he was part of
22 that.

23 BY MR. ERCOLE:

24 Q. Do you know whether Cephalon had any role
25 whatsoever in creating the content of the 2004 model

1 policy?

2 MS. BALDWIN: Object to form.

3 THE WITNESS: I don't know whether Cephalon
4 was involved or not involved at all, and, therefore,
5 I have no idea what their role could be.

6 BY MR. ERCOLE:

7 Q. Sitting here today, you're not aware of any
8 influence that Cephalon ever exercised in connection
9 with the 2004 model policy by the federation?

10 A. No.

11 MS. BALDWIN: Object to the form.

12 BY MR. ERCOLE:

13 Q. And sitting here today, you're not aware of
14 any influence that Cephalon ever had regarding the
15 1998 model guidelines that were published by the
16 FSMB; is that fair to say?

17 MS. BALDWIN: Object to form.

18 THE WITNESS: I certainly know of none.

19 BY MR. ERCOLE:

20 Q. And concerning the 2004 model policy, can
21 you describe how that process worked in terms of
22 actually coming up with and ratifying that policy?

23 A. Well, I was on the advisory committee that
24 helped look at, you know, what are the issues that
25 medical boards need to be concerned about when

1 they're reviewing prescribers' behavior and
2 activities, so it was kind of a consensus process of
3 trying to come up with the most important points that
4 boards would need to know, and then I believe that
5 content was written up and then brought to the
6 federation, to their committees, and then they
7 brought it to their House of Delegates, and it -- you
8 know, it was a full voting process where every board
9 got to vote on it, and it was ultimately passed or
10 ratified.

11 Q. And sounds like there was a significant
12 review process associated with those particular
13 guidelines.

14 A. I believe --

15 MS. BALDWIN: Objection. Leading.

16 THE WITNESS: I believe so.

17 BY MR. ERCOLE:

18 Q. And sitting here today, you're not aware of
19 any sort of improper influence that pharmaceutical
20 companies would have had in the creation of those
21 particular policies; is that fair to say?

22 MS. BALDWIN: Object to form and leading.

23 THE WITNESS: Yes.

24 BY MR. ERCOLE:

25 Q. And was there also a policy that was issued

1 by the federation in 2012 regarding opioid
2 prescribing?

3 A. Yes.

4 Q. Were you involved in the creation of that
5 policy?

6 A. No.

7 Q. Sitting here today, do you have any
8 knowledge or evidence -- strike that.

9 Sitting here today, do you have any
10 knowledge of any improper influence that
11 pharmaceutical companies had regarding the
12 development of that 2012 policy?

13 MS. BALDWIN: Object to form.

14 THE WITNESS: No.

15 BY MR. ERCOLE:

16 Q. Dr. Fishman, you've been on the board of
17 directors of various third party consumer advocacy
18 and professional associations; is that correct?

19 A. Yes.

20 Q. And the State's counsel asked you a number
21 of questions about the American Pain Foundation.

22 A. Correct.

23 Q. Do you recall?

24 A. Yes.

25 Q. And what is the American Pain Foundation?

1 A. Well, it was a nonprofit that was focused on
2 advocating and educating consumers around pain
3 control.

4 Q. Okay. And do you recall when you were on
5 the board of directors of that particular
6 association?

7 A. I think I was on from 2006 to 2011.

8 Q. And when you say -- you mentioned that the
9 nonprofit was focused on advocating and educating
10 consumers. When you're referring to consumers, who
11 are you referring to?

12 MS. BALDWIN: Object to form.

13 THE WITNESS: People affected by pain and
14 those who -- either people affected directly or
15 indirectly by having pain.

16 BY MR. ERCOLE:

17 Q. And did the American Pain Foundation
18 actually help those consumers?

19 MS. BALDWIN: Objection. Leading.

20 THE WITNESS: I believe they did.

21 BY MR. ERCOLE:

22 Q. And if you didn't believe the American Pain
23 Foundation was helping consumers, is it fair to say
24 that you wouldn't have been on the board of directors
25 for the time that you were?

1 MS. BALDWIN: Objection. Leading.

2 THE WITNESS: I would absolutely agree with
3 that.

4 BY MR. ERCOLE:

5 Q. Was the American Pain Foundation made up of
6 medical professionals?

7 MS. BALDWIN: Objection. Leading.

8 THE WITNESS: Well, the board of directors
9 of the American Pain Foundation started as a group of
10 medical professionals and evolved into a mixed group
11 of consumers, patients in pain, consumers and medical
12 professionals, and it was trending to evolve toward
13 medical -- towards consumers taking over the American
14 Pain Foundation as their concern rather than being
15 run by medical professionals as it had been in its
16 earlier form.

17 BY MR. ERCOLE:

18 Q. Are you aware of -- strike that.

19 Did the American Pain Foundation put forward
20 publications of any sort?

21 A. Yes.

22 Q. With respect to those publications, did the
23 American Pain Foundation, in your view, independently
24 create those publications?

25 MS. BALDWIN: Object to form.

1 THE WITNESS: Well, I think so. You know, I
2 was on the board of directors and for a time was the
3 chair of the board, and it was our goal that they
4 were completely independent. I wasn't on the ground
5 working with staff preparing these products, this
6 work product, so it's hard for me to say with
7 certainty they were completely independent, but that
8 was certainly the intent.

9 BY MR. ERCOLE:

10 Q. Sure. Well, sitting here today, can you
11 identify any publication from the American Pain
12 Foundation that was not created independently?

13 A. No.

14 MS. BALDWIN: Object to form.

15 BY MR. ERCOLE:

16 Q. And by "independently," do you understand
17 I'm referring to sort of independent from the
18 influence of the pharmaceutical industry?

19 A. Correct.

20 MS. BALDWIN: Object to form.

21 BY MR. ERCOLE:

22 Q. You've also referenced before the American
23 Academy of Pain Medicine -- or at least do you recall
24 the discussion you had with the State about the
25 American Academy of Pain Medicine?

1 A. Yes.

2 Q. Okay. And were you the president of the
3 American Academy of Pain Medicine?

4 A. Yes, from 2005 to 2006.

5 Q. Were you then on the board of directors of
6 the American Academy of Pain Medicine too?

7 A. Yes. I was on the board prior to being
8 president and after.

9 Q. Did pharmaceutical companies control the
10 opinions of the board of directors for the American
11 Academy of Pain Medicine?

12 MS. BALDWIN: Object to form.

13 MR. ZAKRZEWSKI: Form.

14 THE WITNESS: No.

15 BY MR. ERCOLE:

16 Q. Did pharmaceutical companies dictate the
17 opinions of the board of directors for the American
18 Academy of Pain Medicine?

19 MS. BALDWIN: Object to form.

20 MR. ZAKRZEWSKI: Object to form.

21 MS. BALDWIN: Leading.

22 THE WITNESS: I can't speak to what -- the
23 opinions of other members of the board. My
24 experience was that the board was not controlled by
25 pharmaceutical company influences.

1 BY MR. ERCOLE:

2 Q. And was that the same for the American Pain
3 Foundation, too, at least to the best of your
4 knowledge?

5 MS. BALDWIN: Object to form. Leading.

6 THE WITNESS: Yes.

7 BY MR. ERCOLE:

8 Q. And what was the American -- or what is the
9 American Academy of Pain Medicine?

10 A. It's a professional organization of
11 clinicians working in the area of pain management.

12 Q. And does it have a mission statement?

13 A. It does.

14 Q. Do you know generally what that mission
15 statement is?

16 A. You know, I would imagine it states that
17 it's an organization that supports the practice of
18 pain medicine and the safe and effective provision of
19 pain relief.

20 Q. And did the American Academy of Pain
21 Medicine create publications regarding pain
22 management?

23 A. Yes.

24 Q. Did they create publications regarding
25 opioids?

1 A. They did.

2 Q. Is it fair to say that if you thought the
3 American Academy of Pain Medicine was somehow
4 improperly influenced by pharmaceutical companies,
5 you would not have been on the board of directors for
6 that organization?

7 MS. BALDWIN: Object to form. Leading.

8 THE WITNESS: Yes.

9 BY MR. ERCOLE:

10 Q. Is is fair to say that if you thought the
11 American Academy of Pain Medicine was somehow
12 improperly influenced by pharmaceutical companies,
13 you would not have been the president of that
14 organization?

15 A. Correct.

16 MS. BALDWIN: Object to form. Leading.

17 BY MR. ERCOLE:

18 Q. Sitting here today, can you identify any
19 publication put forward by the American Academy of
20 Pain Medicine that was not independently created by
21 that particular organization?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: Again, the academy probably
24 has done many publications that are in consortium
25 with others that they don't independently produce

1 that they're collaborators on, but I believe their
2 parts are always independent.

3 BY MR. ERCOLE:

4 Q. Okay. Sitting here today, can you identify
5 any publication from the American Academy of Pain
6 Medicine that was somehow improperly influenced by --

7 MS. BALDWIN: Object to form.

8 BY MR. ERCOLE:

9 Q. -- by pharmaceutical company?

10 MS. BALDWIN: Sorry. Object to form.

11 THE WITNESS: No.

12 BY MR. ERCOLE:

13 Q. You also, sir, served on the board of
14 directors for the American Pain Society?

15 A. Yes.

16 Q. Is the American Pain Society still in
17 existence today?

18 A. It is.

19 Q. What is the American Pain Society?

20 A. It's again another professional group of
21 clinicians engaged with the focus on pain relief.

22 Q. And would the American Pain Society sponsor
23 certain projects to help with pain relief?

24 A. Yes.

25 Q. Okay. Can you give me an example of some of

1 those projects?

2 A. Well, they would hold conferences and
3 produce materials, publications that would be in the
4 realm of pain management.

5 Q. And is it fair to say that if you thought
6 the American Pain Society was being improperly
7 influenced by pharmaceutical companies, you would not
8 have been on the board of directors of that
9 organization?

10 MS. BALDWIN: Object to form and leading.

11 THE WITNESS: Correct.

12 BY MR. ERCOLE:

13 Q. Sitting here today, can you identify --
14 strike that.

15 Sitting here today, are you aware of any
16 publications put forward by the American Pain Society
17 that were somehow improperly influenced by
18 pharmaceutical companies?

19 MS. BALDWIN: Object to form.

20 THE WITNESS: No.

21 BY MR. ERCOLE:

22 Q. Are you aware of any instance where a
23 pharmaceutical company dictated the content of any
24 publication put forward by the American Pain Society?

25 A. No.

1 MS. BALDWIN: Object to form.

2 BY MR. ERCOLE:

3 Q. And I'll ask that just generally as to the
4 various associations that you've been involved with.
5 Are you familiar with -- are you aware of any
6 instance where any pharmaceutical company dictated
7 the content of any publication put forward by the
8 American Pain Society, the American Academy of Pain
9 Medicine or the American Pain Foundation?

10 MS. BALDWIN: Object to form.

11 THE WITNESS: Well, you're asking me a very
12 broad question.

13 BY MR. ERCOLE:

14 Q. Sure.

15 A. There's one area where I think there's
16 influence in drug companies. I don't have a specific
17 one, not your company or any other specific ones
18 here, but in the -- working with these medical
19 education companies that put on a lot of the CME
20 activities, you know, my concern is that there's
21 influence from pharmaceutical companies who sponsor
22 programs, and that influence gets translated to the
23 educators in the program subtly as if it's -- as if
24 it's not messaging, as if it's independent of the
25 sponsor.

1 So that would be the one area where, you
2 know, all of these groups participate with medical
3 education companies because they come with funding to
4 help them put on conferences that otherwise they
5 wouldn't be able to put on for their members, they
6 wouldn't be able to afford, and they do these
7 marketing-type trainings, and I think that there's a
8 line there that often gets crossed, and, you know,
9 frankly, I think pharmaceutical companies know that
10 that's a permeable wall that they can work with.

11 So that would be my one place where I do
12 think that the professional organizations like the
13 Academy of Pain Medicine and the American Pain
14 Society and many, many other groups, not limited to
15 pain -- this is a widespread problem across medicine
16 where there's permeability of the influence of
17 industry to the educators of medical education
18 programming.

19 Q. Okay. And sitting here today, are you aware
20 of any instance where Cephalon has ever influenced
21 the content of any CME program as you're describing?

22 A. No.

23 MS. BALDWIN: Object to form.

24 BY MR. ERCOLE:

25 Q. Sitting here today, are you aware of any

1 instance where Teva USA has ever influenced the
2 content of any CME program like what you're
3 describing?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: No.

6 BY MR. ERCOLE:

7 Q. Sitting here today, are you aware if any of
8 the defendants in this particular case has influenced
9 the content of any CME program?

10 MS. BALDWIN: Object to form.

11 THE WITNESS: I don't know of any specific
12 program, no.

13 BY MR. ERCOLE:

14 Q. Well, with respect to the programs -- and
15 you say -- or CME programs, did the American Academy
16 of Pain Medicine, the American Pain Society and the
17 American Pain Foundation -- did they put on CME
18 programs?

19 A. Well, this really applies to the
20 professional organizations, and they don't have to be
21 CME programs.

22 Q. Okay.

23 A. You know, they're basically marketing
24 programs that have a middle man in the form of these
25 media companies who are hired by -- I believe are

1 hired by or get their funding from industry and then
2 are supposed to be arm's length in the middle with
3 the educational speakers, but there's an overlap
4 there that, you know, I've always found uncomfortable
5 and a permeability that I spoke to that I think we
6 have to address.

7 Again, it's not endemic to opioid
8 manufacturers, opioid programs. It's endemic to
9 medical education across the board. So you asked me
10 a very broad question.

11 Q. Sure.

12 A. I feel like I have to say that.

13 Q. Sure. And with respect to the -- when you
14 were at the -- when you were -- strike that.

15 When you were on the board of directors of
16 the American Pain Society, the American Pain Society
17 put on presentations; is that fair to say?

18 A. Yes.

19 Q. Okay. And with respect to any of those
20 presentations, are you aware of any improper
21 influence that pharmaceutical companies exercised
22 over those presentations?

23 MS. BALDWIN: Object to form.

24 THE WITNESS: I'm not aware of any specific
25 programs.

1 BY MR. ERCOLE:

2 Q. Okay. And with respect to the American
3 Academy of Pain Medicine, when you were on the board
4 of directors there as the president, are you aware of
5 any specific programs that pharmaceutical companies
6 improperly influenced there?

7 MS. BALDWIN: Object to form.

8 THE WITNESS: No specific programs.

9 BY MR. ERCOLE:

10 Q. Okay. And with respect to the American Pain
11 Foundation, are you aware of any presentations that
12 the pharmaceutical company improperly influenced in
13 some way?

14 A. No.

15 MS. BALDWIN: Object to form.

16 BY MR. ERCOLE:

17 Q. Okay. How about with respect to those three
18 organizations, are you aware of any statements made
19 in any presentations by those organizations that were
20 false?

21 MS. BALDWIN: Object to form.

22 THE WITNESS: No.

23 BY MR. ERCOLE:

24 Q. Okay. And so is it fair to say you're not
25 aware of any statements made in any of those

1 presentations -- strike that.

2 Is it fair to say, then, that with respect
3 to those organizations, you're not aware of any
4 statements made about opioids in any presentations
5 that were false?

6 MS. BALDWIN: Object to form.

7 THE WITNESS: No.

8 BY MR. ERCOLE:

9 Q. And, in fact, is it fair to say that if you
10 were involved -- strike that.

11 Is it fair to say that you would not have
12 been on the board of directors or been involved with
13 those particular organizations if you thought they
14 were putting out false statements in their
15 presentations?

16 MS. BALDWIN: Object to form. Leading.

17 THE WITNESS: Yes.

18 BY MR. ERCOLE:

19 Q. And if you'd take a look -- can you turn to
20 Exhibit 4 of your -- of the exhibits?

21 (Discussion off the record)

22 MS. BALDWIN: I'm sorry. I'm really
23 confused by your question. What exhibit are you
24 referring to?

25 MR. ERCOLE: It's Exhibit 4 in the documents

1 that were used yesterday.

2 MS. BALDWIN: Okay. Thank you.

3 MR. ZAKRZEWSKI: There's no question yet.
4 He just said refer to Exhibit 4.

5 MS. BALDWIN: And can you tell me the name
6 of the document? Because the court reporter took
7 them all.

8 MR. ERCOLE: Sure. It's -- has "Cephalon"
9 on the top of it.

10 MS. BALDWIN: Okay.

11 MR. ERCOLE: And it's a fully executed
12 agreement.

13 MS. BALDWIN: Thank you.

14 BY MR. ERCOLE:

15 Q. Dr. Fishman, this is a document that the
16 State showed you yesterday as an exhibit. Do you
17 recall that?

18 A. I do.

19 Q. Okay. And if you'd turn to the second page,
20 it refers to an Independent Educational Program Grant
21 Agreement. Do you see that?

22 A. I do.

23 Q. And this particular grant agreement
24 involves -- is between Cephalon and the University of
25 California, Davis?

1 A. Yes.

2 Q. And do you recall the State using this
3 agreement as a basis to show that Cephalon funded
4 certain programs put on by the University of
5 California, Davis?

6 MS. BALDWIN: Object to form.

7 THE WITNESS: Yes.

8 BY MR. ERCOLE:

9 Q. And if you'd turn -- the State didn't ask
10 you to actually look at the content of what's in this
11 particular agreement, did it?

12 MS. BALDWIN: Object to form.

13 I allowed the witness to review every
14 document yesterday at his leisure if he requested to
15 do so.

16 THE WITNESS: I'm sorry. Can you restate
17 the question?

18 BY MR. ERCOLE:

19 Q. Sure. The State didn't ask you any
20 questions about the content of this particular
21 Educational Grant Agreement, did it?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: I don't recall them asking me
24 about the content.

25 BY MR. ERCOLE:

1 Q. Okay. And so can you turn to paragraph six
2 of this document?

3 A. "Program Purpose"?

4 Q. Yes. And do you see where it says "This
5 program is for scientific and educational purposes
6 only and is not intended to promote a Cephalon
7 product, directly or indirectly"?

8 MS. BALDWIN: Object to form.

9 BY MR. ERCOLE:

10 Q. Do you see that?

11 A. Yes, I do.

12 Q. Is that consistent with your understanding
13 of what sort of independent programs were being put
14 forth by University of California, Davis?

15 MS. BALDWIN: Object to form. Leading.

16 THE WITNESS: Yes. And I think it's
17 supported if you look at the actual content of the
18 program that they supported.

19 BY MR. ERCOLE:

20 Q. And if you'd turn to paragraph eight of this
21 document, do you see that there's a provision that
22 says "The IEP provider," and the IEP provider is the
23 University of California at Davis? Do you understand
24 that?

25 A. I do.

1 Q. Okay. And it says "The IEP provider shall
2 retain full responsibility for control of the content
3 of the program and shall ensure that the following
4 requirements are met." Do you see that?

5 A. I do.

6 Q. And that was, at least according to this
7 document, a condition that Cephalon required in order
8 to give a grant for purposes of this presentation; is
9 that correct?

10 MS. BALDWIN: Object to form. Leading.

11 THE WITNESS: Yes.

12 BY MR. ERCOLE:

13 Q. And was that consistent with your
14 understanding of the presentation that was actually
15 put forward?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: Are you asking me if the
18 presentation that we put forward was consistent with
19 what I think the spirit of this is?

20 BY MR. ERCOLE:

21 Q. Yes.

22 A. Yeah.

23 MS. BALDWIN: Object to form.

24 THE WITNESS: This is under "Objectivity and
25 Balance," and if you look at the program, it doesn't

1 even have content that would discuss Cephalon's
2 products.

3 BY MR. ERCOLE:

4 Q. And if you'd look at 8-B where it says "IEP
5 provider agrees that neither Cephalon nor its agents
6 shall control the content of the program." Do you
7 see that?

8 A. I do.

9 MS. BALDWIN: Object to form.

10 BY MR. ERCOLE:

11 Q. And was that that requirement that neither
12 Cephalon nor its agents shall control the content of
13 the program, consistent with the various CME programs
14 that you put on that were supported directly or
15 indirectly by Cephalon?

16 MS. BALDWIN: Object to form and leading.

17 THE WITNESS: We always controlled the
18 content of our CME programs, and no outside
19 influences would change that.

20 BY MR. ERCOLE:

21 Q. And if you'd turn to paragraph nine of this
22 document, it refers to something called a Risk
23 Minimization Action Plan.

24 A. Uh-huh.

25 Q. Do you know what a Risk Minimization Action

1 Plan is?

2 A. It's a -- to my knowledge, a post-marketing
3 intervention by the FDA to transparently document how
4 these drugs, these dangerous drugs -- the strategies
5 for how the risks would be minimized in using these
6 dangerous drugs.

7 Q. And if you turn to paragraph nine, it says
8 "A risk map." Have you heard -- have you heard that
9 phrase before, "risk map"?

10 A. Yes.

11 MS. BALDWIN: Objection to form.

12 BY MR. ERCOLE:

13 Q. Is that the same as a Risk Minimization
14 Action Plan?

15 A. Correct.

16 Q. It says "A risk map is a strategic safety
17 program designed to meet specific goals and
18 objectives in minimizing known risks of a product
19 while preserving its benefits. Do you see that?

20 A. I do.

21 MS. BALDWIN: Object to form.

22 BY MR. ERCOLE:

23 Q. And with respect to the risks of a product,
24 would that include, at least for opioid medicines,
25 the risks for addiction and abuse?

1 MS. BALDWIN: Object to form.

2 THE WITNESS: Yes.

3 MS. BALDWIN: Leading.

4 BY MR. ERCOLE:

5 Q. And those were FDA -- strike that.

6 To the best of your knowledge, was a risk
7 map an FDA required program?

8 A. I believe so.

9 MS. BALDWIN: Object to form.

10 BY MR. ERCOLE:

11 Q. And if you'd turn to the last two pages of
12 this document.

13 A. Uh-huh. Yeah.

14 Q. There's a reference on Exhibit B --

15 A. Uh-huh.

16 Q. -- to the Actiq Risk Management Program,
17 A-c-t-i-q, Risk Management Program. Do you see that?

18 A. I do.

19 Q. And underneath that, there's a paragraph,
20 says "Provider is aware that Actiq was approved
21 subject to a Risk Management Program."

22 A. Yes.

23 MS. BALDWIN: Object to form.

24 BY MR. ERCOLE:

25 Q. And it goes on to say "The RMP includes key

1 safety messages that are essential to the safe use of
2 a product"?

3 A. Yes.

4 MS. BALDWIN: Object to form.

5 BY MR. ERCOLE:

6 Q. So in connection with this particular
7 program that Cephalon provided a grant for, Cephalon
8 was informing the provider that Actiq comes with an
9 FDA-approved Risk Management Program; is that
10 correct?

11 MS. BALDWIN: Object to form. Leading.

12 THE WITNESS: I'm not sure that's exactly
13 correct. They attach to their agreement that
14 information. I'm not sure what the purpose of them
15 matching that here is. I think they probably felt
16 like they wanted to be as complete as they could be
17 to make sure that if their product -- if this type of
18 opioid had been part of the content, that we would
19 potentially include this, but it was irrelevant
20 because we didn't talk about transmucosal fentanyl.

21 BY MR. ERCOLE:

22 Q. And if you turn to Exhibit -- turn to the
23 following page, there's a reference to the Fentora
24 Risk Management Program.

25 A. Right.

1 Q. And is it fair to say that Fentora also came
2 with an FDA-approved Risk Management Program?

3 A. Exactly. And both are transmucosal rapid
4 onset opioids.

5 Q. Okay. And one or two final questions before
6 we take a break.

7 If you turn back to paragraph nine of the
8 agreement, do you see the last sentence there?

9 A. "Any product marketed by Cephalon that is
10 approved with a risk map and the key safety-related
11 health outcome, as outlined in the risk map, are
12 listed in Exhibit B." Oh. "The IEP provider agrees
13 that it is aware of the risk map and the key safety
14 messages."

15 Q. Sure. And so at least for projects that
16 were being sponsored by Cephalon, it wanted providers
17 to know that its products came with these
18 FDA-approved risk maps; correct?

19 MS. BALDWIN: Object to form and leading.

20 THE WITNESS: I think this demonstrates that
21 Cephalon wanted the risks to be fully known in giving
22 this grant.

23 BY MR. ERCOLE:

24 Q. Sure. And if you turn to the last page,
25 Exhibit B again, some of the key safety messages that

1 are listed there includes the indication for the
2 particular medicine; is that true?

3 A. Correct.

4 MS. BALDWIN: Object to form.

5 THE WITNESS: The limited indication.

6 BY MR. ERCOLE:

7 Q. Limited indication; correct? And it also
8 includes some of the contraindications of the
9 medicine too?

10 A. Yes.

11 Q. And it includes some of the risks associated
12 with prescribing this medicine; correct?

13 MS. BALDWIN: Object to form.

14 THE WITNESS: Yes.

15 BY MR. ERCOLE:

16 Q. Okay. Let's take a break. Thanks.

17 VIDEO OPERATOR: Okay. We're off the
18 record. It's 10:48.

19 (Recess)

20 VIDEO OPERATOR: Okay. We're back on the
21 record. It's 11:07.

22 BY MR. ERCOLE:

23 Q. Dr. Fishman, before we broke, took a break,
24 we were speaking about the risk maps for Actiq and
25 Fentora. Do you recall that?

1 A. Yes.

2 Q. In your view, should a prescriber be aware
3 that a product comes -- or is subject to a risk map
4 before writing a prescription for that product?

5 MS. BALDWIN: Objection. Form.

6 THE WITNESS: Yes.

7 BY MR. ERCOLE:

8 Q. And should --

9 A. At least to the content of that risk map.

10 Q. Fair enough. And if a provider or
11 prescriber is not aware of the content of that risk
12 map for some reason, that could lead to inappropriate
13 prescribing of medicine; is that fair to say?

14 A. Yes.

15 MS. BALDWIN: Objection. Leading.

16 BY MR. ERCOLE:

17 Q. Dr. Fishman, the State yesterday -- strike
18 that.

19 Yesterday, the State asked you a number of
20 questions about the intent of the defendants in this
21 case. Do you recall some of those questions?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: Not generally about the intent
24 of, but perhaps I --

25 BY MR. ERCOLE:

1 Q. Okay. You have no knowledge one way or the
2 other about the intent of any pharmaceutical company
3 regarding marketing practices, do you?

4 MS. BALDWIN: Object to form and leading.

5 THE WITNESS: I have no knowledge of the
6 intent of any of the pharmaceutical companies or
7 their marketing.

8 BY MR. ERCOLE:

9 Q. Do you have any knowledge about the intent
10 of any pharmaceutical companies in this case that are
11 named as defendants regarding their marketing?

12 MS. BALDWIN: Object to form and leading.

13 THE WITNESS: No.

14 BY MR. ERCOLE:

15 Q. And you're not giving an opinion on what any
16 defendant in this case intended or didn't intend, are
17 you?

18 MS. BALDWIN: Object to form and leading.

19 THE WITNESS: I have no knowledge of intent,
20 and I couldn't give an opinion.

21 BY MR. ERCOLE:

22 Q. And you're here as a fact witness; is that
23 fair?

24 MR. ZAKRZEWSKI: Objection.

25 MS. BALDWIN: Object to form.

1 MR. ZAKRZEWSKI: Form.

2 THE WITNESS: I'm not sure what a fact
3 witness -- I was subpoenaed to be here, and I'm here
4 giving you my truthful opinions.

5 BY MR. ERCOLE:

6 Q. Fair enough. Sir, have you ever prescribed
7 opioids for cancer pain?

8 A. Yes.

9 Q. And have you ever prescribed opioids for
10 noncancer pain?

11 A. Yes.

12 Q. Do you continue to prescribe opioids for
13 noncancer pain?

14 A. Yes.

15 Q. With respect to noncancer pain, can you give
16 me a -- sort of a list of some of the conditions for
17 which you've prescribed them?

18 MS. BALDWIN: Object to form.

19 THE WITNESS: Are you asking me what kinds
20 of conditions would I use an opioid for in a
21 noncancer pain, patient with noncancer pain?

22 BY MR. ERCOLE:

23 Q. Sure. That's exactly what I'm asking.

24 A. It's rare that I would use an opioid for
25 chronic noncancer pain other than a short-term

1 exposure. The cases where you would potentially
2 think of and use an opioid are where the benefits
3 would have to outweigh the risks. Today, we know
4 risks that we didn't know ten years ago based on much
5 more solid data.

6 In fact, the data on the benefits of opioids
7 is weak and really not very convincing. The data on
8 risk is growing and increasingly convincing of the
9 risks that are involved.

10 So the decisions that I would make today
11 about giving an opioid, the process would be exactly
12 the same, but since the elements of the risk benefit
13 equation have now changed, that the outcome of that
14 equation would be different today.

15 So there are very few cases where I find
16 that the benefits outweigh the risks, but there are
17 cases, and I can give you an example of one.

18 Q. Sure.

19 A. You know, a patient -- and this is a real
20 case: A patient who has a disease called spinal
21 stenosis, which is where the opening in the middle of
22 the spine that houses the spinal cord becomes
23 degenerated and becomes narrower and narrower because
24 of the deposition of calcium and other elements of
25 degeneration of the spine.

1 It's a mechanical problem that basically
2 suffocates the spinal cord or the spinal roots, and
3 patients get pain when they stand up and they start
4 walking because it essentially increases that
5 compression on the nerves or the cord.

6 Patients who get this problem largely are
7 older and get it because of years and years of
8 deconditioning and degeneration. These are the same
9 people who often have many comorbidities that might
10 limit them from being able to treat them, the
11 mechanical problem with the mechanical solution they
12 need, which is surgical decompression, so many of
13 those patients can't have surgery that they
14 absolutely need, is maybe the only option to reverse
15 the condition because they wouldn't survive the
16 surgery because of the other diseases that they have
17 that aren't actually independent of the spinal
18 stenosis itself.

19 So with that, there are, you know, rare
20 cases where a patient might need a small dose of an
21 opioid after trying all the other options that are
22 less risky to maintain their ability to walk and
23 function and have a life that I would believe would
24 have quality to it. Those cases don't occur very
25 much, and I work in a clinic where we tend to select

1 for patients like that, and it's even rare in a
2 clinic like that.

3 So, again, I want to stress it's not common
4 that we would prescribe opioids for chronic pain, but
5 there are cases in which the benefits -- the benefits
6 would be perceived to outweigh the risks on careful
7 examination, and these are patients who we might
8 prescribe an opioid chronically.

9 Q. And with respect to the patient that you
10 gave an example of, has that patient benefited from
11 the opioid prescriptions you've written?

12 MS. BALDWIN: Object to form.

13 THE WITNESS: I believe that patient has,
14 and, in fact, it's a case of a patient who came to me
15 because they were benefiting from the opioids, and
16 their physicians were afraid that they shouldn't be
17 on opioids, so they took them off, and their function
18 greatly deteriorated, and then we were able to come
19 up with a plan that everyone was agreeable to, the
20 prescribers and the specialists and the patient, and
21 we had an agreement around how much would be used,
22 etc., so that, you know, the patient could go back to
23 their level of previous function.

24 BY MR. ERCOLE:

25 Q. And whether or not the -- strike that.

1 In determining whether or not the risks of
2 opioids outweigh the benefits or the benefits
3 outweigh the risks, is that an individualized
4 determination by patient?

5 MS. BALDWIN: Object to form.

6 MR. ZAKRZEWSKI: Objection.

7 THE WITNESS: Absolutely an individualized
8 decision, and it's also individually based on what
9 the treatment is as well. So, for instance, you
10 might accept using a treatment at low dose but not at
11 high dose. So this was -- the case that I gave you
12 was a patient who did very well on a very moderate
13 amount of medication that was ultimately acceptable
14 for long-term use.

15 BY MR. ERCOLE:

16 Q. And have you prescribed opioids for other
17 noncancer-related pain conditions in your career
18 other than the example that you just identified?

19 A. Yes.

20 Q. Okay. And what are some of those instances
21 where you prescribed opioids for noncancer pain?

22 A. Well, they're too numerous to mention to
23 list it all, but they were all cases where, again,
24 opioids were not the first option, they were a late
25 option, and they were viewed as having less risk than

1 many of the other options that we had at hand.

2 So, for instance, a patient who has kidney
3 disease and can't take any inflammatories or is on an
4 anticoagulant medication and can't take any
5 inflammatory medications, patients who really don't
6 have any other options for many different chronic
7 conditions and don't have any other ways of
8 maintaining their function, I think it's appropriate
9 to at least consider an opioid as one of the options.
10 Again, these are rare.

11 If I can add, I should also emphasize that
12 it's even more -- it's even rarer to need high doses
13 of these opioids.

14 Q. And with respect to the cases where you've
15 prescribed opioids for noncancer or related
16 conditions, I know you've now indicated that there
17 was an instance where you prescribed -- strike that.

18 You indicated that the instances where you
19 prescribed opioids for noncancer pain are too
20 numerous to mention. Did I read that -- is that
21 accurate?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: The kind of cases that would
24 be appropriate are too numerous.

25 BY MR. ERCOLE:

1 Q. Right. And in determining whether or not an
2 opioid prescription is appropriate for noncancer
3 pain, do you exercise your own independent medical
4 judgment in making that determination?

5 A. Absolutely.

6 Q. And is the age of the patient a factor that
7 you consider in making that determination?

8 A. It would definitely be a factor.

9 Q. Is whether or not the patient tried other
10 alternatives to opioids a factor that you would
11 consider in making that determination?

12 A. Yes.

13 Q. The risks of opioids -- strike that.
14 The risk of the particular opioid that's
15 being contemplated, is that something that you would
16 consider?

17 A. Yes.

18 Q. Medical history of the patient, is that
19 something you would consider?

20 A. Yes.

21 Q. Medical literature out there, is that
22 something you would consider in making a
23 determination as to what would be -- whether or not
24 an opioid would be appropriate for a patient?

25 A. Yes.

1 Q. Your history prescribing opioids, is that
2 something that you would consider in making a
3 determination?

4 A. My --

5 MS. BALDWIN: Object to form.

6 MR. ERCOLE: Sure. I'll rephrase it.

7 BY MR. ERCOLE:

8 Q. Your prior clinical experience with the
9 particular medicine at issue, is that something that
10 you would consider?

11 A. Yes.

12 Q. How about the patient's pain level? Is that
13 something you would consider?

14 A. Yes.

15 Q. Nature of the pain, is that something that
16 you would consider?

17 A. Absolutely.

18 Q. Patient's -- any history of abuse or
19 addiction with that patient, is that something you
20 would consider?

21 A. Absolutely.

22 Q. All of these are individualized factors that
23 go into a prescribing decision; is that fair to say?

24 MS. BALDWIN: Object to form.

25 THE WITNESS: They're some of the factors

1 that go into the decision to treat or not treat.

2 BY MR. ERCOLE:

3 Q. And what are some of the other factors that
4 you would consider in making a determination as to
5 whether or not to prescribe an opioid for a
6 particular patient?

7 A. Well, it would include the contraindications
8 of the drugs, the patient's -- you know, other
9 comorbidities, the patient's ability to take the drug
10 safely, to store the medication safely, the patient's
11 ability to modulate their own use, you know,
12 functional assessments because you asked me about
13 pain -- the pain level.

14 The pain is completely subjective, to we'd
15 want to look at objective measures around, you know,
16 asking questions like, "What is it that you can't do
17 now that you'd want to be able to do?" and being able
18 to feel comfortable, that we've set up a paradigm in
19 which we could see a function improved or declined
20 with the medications. That's just some examples.

21 Q. Any other factors that you can think of?

22 A. I'm sure there are others, but I can't think
23 of them off the top of my head.

24 Q. And how about whether or not the medicine is
25 subject to a risk map, for instance? That impact

1 your -- could impact your decision making?

2 MS. BALDWIN: Object to form.

3 THE WITNESS: Well, you know, there's
4 something called a REMS, a risk evaluation mitigation
5 strategy, that some opioids have mandatory processes
6 that you're going to attend to if you're going to use
7 the drugs, and some of the transmucosal drugs have a
8 mandatory REMS, so you'd need to address that risk
9 map directly with those drugs.

10 You know, again, I hate to use the word
11 "risk map" because clinicians might not know the risk
12 map, but they should know the content within the risk
13 map.

14 BY MR. ERCOLE:

15 Q. And you mentioned REMS program.

16 A. Uh-huh.

17 Q. Do you know whether or not Actiq and
18 Fentora -- strike that.

19 Have you ever heard the phrase "TIRF REMS"?

20 A. Yes.

21 Q. And what is "TIRF REMS"?

22 A. They're the risk evaluation mitigation
23 program that has a mandatory education component for
24 transmucosal fentanyl products.

25 Q. And do you know what that mandatory

1 educational program requires before writing a
2 prescription of a TIRF medicine?

3 A. I believe it requires an online training.

4 Q. Sorry. I'm just pulling out a document. I
5 don't mean to be --

6 A. Okay.

7 Q. -- rude. And have you -- we talked about
8 Actiq and Fentora. Are those medicines subject to
9 the TIRF REMS program?

10 A. I believe so.

11 Q. And Actiq and Fentora are rapid onset
12 opioids?

13 A. Correct.

14 Q. Okay. And have you ever prescribed Actiq
15 before?

16 A. You know, I don't believe I have.

17 Q. Have you ever prescribed Fentora before?

18 A. I don't recall prescribing it.

19 Q. Are you enrolled in the TIRF REMS program?

20 A. No.

21 Q. Okay. Are you familiar with the concept of
22 breakthrough pain?

23 A. I am.

24 Q. And what is breakthrough pain?

25 A. Breakthrough pain is pain that rises above a

1 steady level of pain, so separate from -- you know,
2 kind of pain that spikes through a steady level of
3 pain.

4 Q. Is breakthrough pain a public health problem
5 for patients?

6 MS. BALDWIN: Object to form.

7 BY MR. ERCOLE:

8 Q. Strike that.

9 Is breakthrough pain a problem for patients?

10 MS. BALDWIN: Object to form.

11 THE WITNESS: For some patients.

12 BY MR. ERCOLE:

13 Q. And what are some of the consequences of
14 breakthrough pain --

15 MS. BALDWIN: Object to form.

16 BY MR. ERCOLE:

17 Q. -- for patients?

18 A. Suffering, decreased function, diminished
19 health.

20 Q. Any other functional limitations?

21 A. There can be a myriad of problems that fall
22 from those.

23 Q. And Actiq and Fentora are indicated for the
24 treatment of breakthrough pain in cancer patients
25 that are opioid tolerant; is that your understanding?

1 A. Correct.

2 Q. And in your view, is there a difference
3 between breakthrough cancer pain and breakthrough
4 noncancer pain?

5 MS. BALDWIN: Object to form.

6 THE WITNESS: Well, I mean, it's different
7 in its nature, but ultimately, you know, there's a
8 lot of commonality to it.

9 BY MR. ERCOLE:

10 Q. And when you say "a lot of commonality,"
11 what do you mean by that?

12 A. Well, you know, breakthrough pain in people
13 with chronic pain, you know, there are different
14 etiologies, different reasons why they have pain, but
15 ultimately, it meets the same criteria of pain that
16 spikes through a basic level of steady, constant
17 pain.

18 Q. With respect to the TIRF REMS program that
19 you were referring to earlier, is it your
20 understanding that before a prescriber can write a
21 prescription of Actiq and Fentora, they have to go
22 through a mandatory educational program?

23 A. I believe so.

24 MS. BALDWIN: Object to form.

25 BY MR. ERCOLE:

1 Q. And is it your understanding that that
2 mandatory educational program would highlight the
3 indications of those particular medicines?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: Yes.

6 BY MR. ERCOLE:

7 Q. And would that mandatory educational program
8 highlight the risks associated with prescribing those
9 medicines?

10 MS. BALDWIN: Object to form.

11 THE WITNESS: Yes.

12 BY MR. ERCOLE:

13 Q. Is it your understanding that before a
14 prescription of Actiq or Fentora is written as a
15 result of the TIRF REMS program, that a doctor and
16 patient have to sign a actual formal agreement before
17 a prescription is written?

18 MS. BALDWIN: Object to form.

19 THE WITNESS: I'm not sure about that.

20 BY MR. ERCOLE:

21 Q. Doctor, with respect to breakthrough pain,
22 do you believe that -- let me show you. Let's mark
23 this as 38.

24 (Exhibit 38 marked)

25 BY MR. ERCOLE:

1 Q. Dr. Fishman, is this a CME program that you
2 authored?

3 A. Yes.

4 Q. And it's "Advances in Assessing and Managing
5 Breakthrough Pain"? Is that the title of it?

6 A. Correct.

7 Q. And if you'd turn to the -- what's marked as
8 Fish 80 on the bottom. Do you see that page?

9 A. Yeah.

10 Q. And if you'd look at the first sentence on
11 that page, the full sentence, it says "Current
12 studies suggest that BPT" -- is that referring to
13 breakthrough pain?

14 A. Uh-huh.

15 Q. -- "occurs in as many as 95 percent of all
16 patients treated for pain, depending on the
17 population surveyed and the definition of
18 breakthrough pain used in investigation."

19 MS. BALDWIN: Object to form.

20 BY MR. ERCOLE:

21 Q. Is that -- did I read that accurately?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: It states that "Current
24 studies suggest that breakthrough pain occurs in as
25 many as 95 percent of all patients treating pain,

1 depending on the population surveyed and the
2 definition of breakthrough pain used in the
3 investigation."

4 BY MR. ERCOLE:

5 Q. And then it goes on to talk about the public
6 health consequences of breakthrough pain. Do you see
7 that?

8 A. I do.

9 Q. And it says "Breakthrough pain is a major
10 component of the public health problem related to the
11 undertreatment of pain." Do you see that?

12 A. I do.

13 MS. BALDWIN: Object to form.

14 BY MR. ERCOLE:

15 Q. And it goes on to say "which has become a
16 national quality of care issue and is a priority
17 concern."

18 MS. BALDWIN: Object to form.

19 BY MR. ERCOLE:

20 Q. Is that accurate?

21 A. Yes.

22 Q. And do you agree that breakthrough pain is
23 a -- remains a major component of the undertreatment
24 of pain in the United States?

25 MS. BALDWIN: Object to form.

1 THE WITNESS: It's a continuing problem.
2 It's a -- I've got to say it's an area that I think
3 we maybe have -- we overreacted to and that, you
4 know, we -- sometimes we -- the treatment was worse
5 than the disease in this area. So I'm looking at
6 this and thinking, you know, we probably would
7 rewrite this differently today.

8 BY MR. ERCOLE:

9 Q. But, sir, you authored this document in
10 2005; is that correct?

11 A. Yeah.

12 Q. And this was your independent work; true?

13 A. Correct. I said "we."

14 MS. BALDWIN: Object to form.

15 BY MR. ERCOLE:

16 Q. Sure.

17 A. I used the term "we."

18 Q. Okay.

19 A. This was done -- you know, I was the lead
20 author of this but in conjunction, you'll see, with
21 others.

22 Q. Okay.

23 A. Other leaders in the field.

24 Q. And at least in 2005, if you look at the
25 public health consequences, on the page, it talks

1 about how breakthrough -- if you turn to the
2 paragraph on page 80, "Breakthrough pain
3 significantly adds to healthcare costs." Do you see
4 that sentence?

5 MS. BALDWIN: Object to form.

6 THE WITNESS: I do.

7 BY MR. ERCOLE:

8 Q. Okay. And is that -- was that a fair and
9 accurate statement in 2005, that breakthrough pain
10 significantly adds to healthcare costs?

11 A. Yes.

12 MS. BALDWIN: Objection to form and leading.

13 BY MR. ERCOLE:

14 Q. And it goes on to say "significantly adds to
15 healthcare costs because it often leads to patient
16 utilization of healthcare resources." Is that
17 accurate then?

18 MS. BALDWIN: Object to form and leading.

19 THE WITNESS: I believe so.

20 BY MR. ERCOLE:

21 Q. And does it continue to be accurate today,
22 that breakthrough pain can add to healthcare costs?

23 A. I think it can.

24 MS. BALDWIN: Object to form.

25 Sorry, Dr. Fishman. I know it's hard.

1 THE WITNESS: It's all right. My fault.
2 I'll wait.

3 BY MR. ERCOLE:

4 Q. And at least with respect to Actiq and
5 Fentora, they are designed to address breakthrough
6 pain in opioid-tolerant noncancer patients; correct?

7 MS. BALDWIN: Objection. Leading.

8 THE WITNESS: My sense were that they were
9 developed for cancer patients.

10 BY MR. ERCOLE:

11 Q. Sure. No. And I apologize for -- yeah.
12 Let me re-correct that. That they were designed to
13 address and indicated for breakthrough pain in
14 opioid-tolerant cancer patients; correct?

15 A. That is correct.

16 Q. And would you agree that Actiq and Fentora
17 can play a significant role in reducing healthcare
18 costs associated with breakthrough pain in
19 opioid-tolerant patients, at least when prescribed
20 appropriately?

21 MS. BALDWIN: Objection. Leading.

22 THE WITNESS: Can you ask that again?

23 BY MR. ERCOLE:

24 Q. Sure. Would you agree that Actiq and
25 Fentora can play a significant role in reducing

1 healthcare costs by treating breakthrough pain in
2 opioid-tolerant patients, at least when prescribed
3 appropriately?

4 MS. BALDWIN: Same objection.

5 THE WITNESS: There's a role for rapid onset
6 opioids in cancer patients, although I think it's a
7 very limited role. How much that they would affect
8 healthcare costs, I think, is a questionable entity.
9 I'm not sure that I would fully support what you
10 said. I guess the answer is I'm not absolutely
11 certain of that.

12 BY MR. ERCOLE:

13 Q. Okay.

14 A. Because these are not inexpensive drugs.

15 Q. You're not absolutely certain one way or the
16 other?

17 A. Yeah.

18 Q. But at least as of 2005, you were
19 highlighting the healthcare costs that are associated
20 with breakthrough pain; correct?

21 MS. BALDWIN: Objection to form and leading.

22 MR. ZAKRZEWSKI: Objection.

23 THE WITNESS: Right. But there's a
24 different between the problem of breakthrough pain
25 and treatment with Fentora and Actiq.

1 BY MR. ERCOLE:

2 Q. Sure. And at least in this article, you are
3 highlighting that breakthrough pain can be treated
4 with rapid onset opioids; correct?

5 A. Right.

6 MS. BALDWIN: Object to form.

7 THE WITNESS: I can tell you where, if you
8 want to know where my concern is with this debate --

9 BY MR. ERCOLE:

10 Q. Sure.

11 A. -- is that I think that the whole
12 breakthrough pain initiative is the right initiative,
13 but it was used by some to look at patients who
14 unwittingly would get more and more opioids because
15 there wasn't really fine-tuned understanding of what
16 was breakthrough pain and why it was breaking
17 through, and it became an excuse to continue to up
18 the doses of opioids.

19 So I'm uncomfortable, and I would have --
20 had I known now what I didn't know then, I would have
21 been more cautious with the way that they crafted the
22 statements here.

23 Q. But, again, the statements here reflect your
24 independent opinions; correct?

25 A. Right, and my lack of knowledge at the time.

1 Q. And when you refer to "used by some to look
2 at patients," you were referring to some physicians;
3 correct?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: I refer to people who use
6 opioids and are looking at breakthrough pain, and
7 rather than, you know, looking at it critically and
8 asking, "How can we address this without increasing
9 the overarching amount of opioid the patient's taking
10 per day?" they used it as an excuse, and I would say
11 unwitting primary care clinicians say, "Okay. Well,
12 you're having breakthrough pain. I'll add a
13 short-acting opioid on top of a long-acting opioid,
14 and then on the next visit, I'll consolidate them."

15 So the long-acting opioid now went up by,
16 you know, 50 percent or something like that, and then
17 the cycle replayed itself until these patients were
18 on huge amounts of opioids without the clinicians
19 really going back and looking, "What are we doing,
20 and what's the ultimate impact of the patient?"
21 largely based on knowledge that we only really
22 supported by clear data within the last ten years
23 that risk goes up with dose.

24 So the risk benefit analysis changes with
25 every dose increase that occurs, and that was not

1 emphasized here, and it should have been. So I'm
2 just happy I could -- I appreciate your indulging me
3 to be able to say that.

4 BY MR. ERCOLE:

5 Q. Sure. And sitting here today, are you aware
6 of -- well, with respect to the physicians who write
7 prescriptions of Actiq or Fentora, as we talked about
8 before they can write a prescription of Actiq and
9 Fentora, they need to pass an educational test saying
10 that they're aware of the risks of those medicines;
11 correct?

12 A. Yes, I believe that is the case.

13 Q. Right.

14 A. It wasn't early on with the introduction of
15 Actiq and Fentora in the market.

16 Q. Sure. But at least, as we looked at
17 earlier, when Actiq and Fentora were passed, they
18 were passed with risk maps.

19 A. Correct.

20 Q. FDA-mandated risk maps; correct?

21 A. Correct.

22 MS. BALDWIN: Object to form.

23 BY MR. ERCOLE:

24 Q. And those risk maps would have highlighted
25 to physicians the risks associated with those

1 medicines; correct?

2 A. Yes.

3 Q. Okay. I just have a couple more questions.

4 Are you aware of any instance where any
5 Oklahoma -- strike that.

6 This is a case, we've talked about, brought
7 by the State of Oklahoma; correct?

8 A. Yes.

9 Q. Okay. And are you aware of any instance
10 where an Oklahoma doctor has been misled in some way
11 into writing a inappropriate prescription of opioids?

12 MS. BALDWIN: Object to form.

13 THE WITNESS: No.

14 BY MR. ERCOLE:

15 Q. Are you aware of any instance where any
16 Oklahoma doctor has been misled by a pharmaceutical
17 company into writing an inappropriate prescription of
18 opioids?

19 MS. BALDWIN: Object to form.

20 THE WITNESS: No.

21 BY MR. ERCOLE:

22 Q. Are you aware of any instance where any
23 Oklahoma doctor has been misled by any of the
24 defendants here into writing a inappropriate
25 prescription of Actiq or Fentora?

1 MS. BALDWIN: Object to form.

2 THE WITNESS: No. And can I just add? I
3 don't know any Oklahoma doctors.

4 BY MR. ERCOLE:

5 Q. Okay. Thank you. I just have one or two
6 final questions, and then I will pass.

7 We've talked about the -- at length about
8 the risks of opioid medicines; right?

9 A. Yes.

10 Q. Okay. I just want to walk through some of
11 the sources by which those risks are disclosed to the
12 medical community if that's okay with you. Is it
13 fair to say in that the -- well, do the labels of
14 opioid medicines disclose the risks?

15 A. Yes.

16 MS. BALDWIN: Object to form. Leading.

17 BY MR. ERCOLE:

18 Q. And those are FDA-approved labels?

19 MS. BALDWIN: Object to form. Leading.

20 THE WITNESS: Yes.

21 BY MR. ERCOLE:

22 Q. And is it expected that physicians would be
23 knowledgeable about the risks in the labels of those
24 medicines before writing a prescription?

25 MS. BALDWIN: Object to form and leading.

1 THE WITNESS: Yes.

2 BY MR. ERCOLE:

3 Q. We've also talked about FDA REMS programs
4 and risk management programs. Are those some of the
5 sources by which the risks of opioids were
6 communicated to the medical community?

7 MS. BALDWIN: Object to form and leading.

8 THE WITNESS: It could be.

9 BY MR. ERCOLE:

10 Q. We also looked at some of your books;
11 correct?

12 A. (Moves head up and down).

13 Q. Was that a source by which the risks of
14 opioids were communicated to the medical community?

15 MS. BALDWIN: Object to form.

16 THE WITNESS: For those who read them.

17 BY MR. ERCOLE:

18 Q. CME programs that you put on, are those some
19 of the sources by which the risks of opioids were
20 communicated to the medical community?

21 A. Yes.

22 MS. BALDWIN: Object to form.

23 BY MR. ERCOLE:

24 Q. Articles that you published, was that
25 another source by which opioids -- excuse me.

1 Was that another source by which the risks
2 of opioids were communicated to the medical
3 community?

4 MS. BALDWIN: Object to form and leading.

5 THE WITNESS: Yes.

6 BY MR. ERCOLE:

7 Q. I believe you mentioned you've been a
8 teacher of medical students for many years now; is
9 that accurate?

10 A. Yes.

11 Q. Okay. Did your teaching communicate to
12 those students the risks of opioid medicine?

13 MS. BALDWIN: Object to form.

14 THE WITNESS: Yes.

15 BY MR. ERCOLE:

16 Q. And is it fair to say that at least if a
17 prescriber wanted to be educated about the risks of
18 opioids, that there were -- and there have been
19 numerous independent sources that have disclosed
20 those risks to providers?

21 MS. BALDWIN: Object to form and leading.

22 THE WITNESS: Yes. I just would add that
23 I'm not sure that there's one place where they all
24 were exhaustively presented, which I think is a --
25 you know, is a shortfall of, you know, everybody

1 involved in trying to do this, you know, that we've
2 really evolved over the last 20 years, mostly in the
3 last ten years, of really understanding what those,
4 you know, risks to making the decision to -- that
5 would go into the decision to prescribe an opioid
6 should be.

7 So with that, you know, there are -- a lot
8 of the risks are well available. Some of them are
9 more subtle and harder for people to find, like the
10 data on benefit for opioids is weak to inadequate,
11 and that's a -- I would say that's a risk that would
12 go into the decision making but not one that was
13 articulated in many places. In fact, not in my book.

14 BY MR. ERCOLE:

15 Q. But at least is it fair to say that if a
16 prescriber had an interest in understanding the risks
17 associated with opioid medicines before writing such
18 a prescription, there were many sources that that
19 provider could turn to to understand those risks?

20 MS. BALDWIN: Object to form and leading.

21 THE WITNESS: I think that's fair.

22 BY MR. ERCOLE:

23 Q. And I know the -- one second.

24 (Pause)

25 BY MR. ERCOLE:

1 Q. The State asked you yesterday a number of
2 questions about Exhibit 7, if you don't mind turning
3 to that document. This will be very quick. Yes.

4 MS. BALDWIN: I'm sorry. Can I just see the
5 document?

6 MR. ERCOLE: Yeah. It's the Key Opinion
7 Leader Development Plan.

8 BY MR. ERCOLE:

9 Q. Have you ever seen this document before,
10 Dr. Fishman?

11 A. I don't believe so.

12 Q. Do you have any idea of how it was created?

13 A. I don't.

14 Q. Do you have any idea who created it?

15 A. Well, it says these two people here, but I
16 don't even know if they work for -- they work for the
17 company or not, and I don't know if this was really a
18 company. This is something that was enacted, so I
19 don't know anything about it.

20 Q. And do you see the word "Draft" on the
21 front?

22 A. I do.

23 Q. And do you have any idea whether or not
24 anything in this document was finalized at the
25 company?

1 MS. BALDWIN: Object to form.

2 THE WITNESS: I do not.

3 BY MR. ERCOLE:

4 Q. Do you have any idea whether anything in
5 this document was actually implemented by the
6 company?

7 MS. BALDWIN: Object to form.

8 THE WITNESS: I do not.

9 BY MR. ERCOLE:

10 Q. And is it fair to say that at least with
11 respect to the internal -- company-specific internal
12 documents that the State showed you yesterday, you
13 have no idea how those documents were developed?

14 MS. BALDWIN: Object to form.

15 THE WITNESS: That is correct.

16 BY MR. ERCOLE:

17 Q. And you have no idea whether or not any of
18 the companies actually implemented what was listed in
19 there or didn't implement them?

20 MS. BALDWIN: Object to form.

21 THE WITNESS: I have no knowledge of how
22 anything was -- whether it was implemented or how it
23 was implemented.

24 BY MR. ERCOLE:

25 Q. No personal knowledge of any of the internal

1 corporate documents that you were shown yesterday by
2 the State; is that fair to say?

3 MS. BALDWIN: Object to form.

4 THE WITNESS: I believe that's true.

5 BY MR. ERCOLE:

6 Q. Okay.

7 MR. EHSAN: Do you want to stop, or do you
8 want to --

9 MR. ZAKRZEWSKI: Let's use the time, please.

10 THE WITNESS: So we should stop a few
11 minutes before noon.

12 MR. ZAKRZEWSKI: Okay. So they can get in
13 here, yeah.

14 THE WITNESS: And we'll need to clear the
15 table. If you can take your stuff, put it just in
16 the back.

17 EXAMINATION

18 BY MR. EHSAN:

19 Q. Good morning, Dr. Fishman. My name is
20 Houman Ehsan. We met yesterday, but I just wanted to
21 introduce myself again on the record.

22 Before yesterday's deposition, have we ever
23 met?

24 A. I don't believe so.

25 Q. I did mention that I had some connection

1 with U.C. Davis Medical School, but I'm -- also,
2 likewise, don't ever recall meeting you in person,
3 but I just wanted to have that question on the
4 record.

5 And for your benefit, doctor, I represent
6 the Janssen/Johnson & Johnson defendants in this
7 litigation. Do you have an understanding one way or
8 the other about the distinction between Janssen and
9 Johnson & Johnson?

10 A. Just that Janssen was an independent company
11 that was purchased by J&J and is a subdivision now of
12 J&J.

13 Q. So to the extent you were asked questions
14 whether a document that may have borne Janssen's logo
15 reflected Johnson & Johnson's thinking, do you have
16 an independent understanding of whether that could be
17 true or not true?

18 A. I do not.

19 MS. BALDWIN: Objection.

20 BY MR. EHSAN:

21 Q. More generally, to the extent that you
22 testified on corporate documents and what the words
23 on those documents may have meant, in any of those
24 instances, did you have an independent understanding
25 of those words beyond what was written on those

1 pages?

2 MS. BALDWIN: Object to form.

3 THE WITNESS: It's hard to know, to review
4 in my mind every one of them, but my recollection is
5 that they -- I'd not seen them before, and I really
6 didn't have any context for them.

7 BY MR. EHSAN:

8 Q. And fair to say you're not a mind reader;
9 correct?

10 MS. BALDWIN: Object to form.

11 THE WITNESS: I knew you were going to ask
12 that. No, I am not a mind reader.

13 BY MR. EHSAN:

14 Q. So you have no independent ability to read
15 what someone may have meant if you had never seen a
16 document before, never spoken to them and had no
17 other basis other than the words written on that
18 page; correct?

19 MS. BALDWIN: Object to form and leading.

20 THE WITNESS: Correct.

21 (Exhibit 39 marked)

22 BY MR. EHSAN:

23 Q. Dr. Fishman, I've handed you what's been
24 marked as Exhibit 39. Do you recognize this
25 document?

1 A. Yes.

2 Q. And how do you recognize it?

3 A. It's a publication of mine from -- published
4 in 1998 -- or accepted for publication in 1998, work
5 that was produced, was conducted in 1997 at Mass
6 General Hospital.

7 Q. And it was published in 1999; correct?

8 A. Correct. It appeared in print in 1999.

9 Q. And what is the subject of this particular
10 publication?

11 A. It's a study of how the opioid contract is
12 used amongst academic centers in the United States.

13 Q. Were opioid contracts used of these by some
14 academic centers in 1997 when you were conducting
15 this research?

16 A. Yes.

17 Q. And that fact is reflected by -- under
18 Table 1 where you list 39 academic centers have
19 submitted such a contract; correct?

20 A. Correct.

21 Q. If you'd look at Table 3, which is on
22 page 31 of the publication as paginated, and let me
23 know when you're there.

24 A. I'm there.

25 Q. Can you explain what Table 3 was attempting

1 to do?

2 A. Table 3 was a attempt to extract -- to
3 assimilate all the contracts we had received and to
4 look at what the most common statements were within
5 the contracts.

6 Q. So just looking at -- and it's a long list.
7 I'm just going to focus your attention on a few
8 examples. If you look at item five, it is identified
9 as "Submit to random drug screen." Do you see that?

10 A. I do.

11 Q. And it states that 27 contracts had that;
12 correct?

13 A. Correct.

14 Q. That represented 69 percent of the contracts
15 you reviewed as part of this study; correct?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: Correct.

18 BY MR. EHSAN:

19 Q. So my interpretation of that is
20 approximately two-thirds of academic medical center
21 opioid contracts had patients submit to random drug
22 screens; correct?

23 MS. BALDWIN: Object to form.

24 THE WITNESS: Correct.

25 BY MR. EHSAN:

1 Q. Likewise, under number eight, certain
2 percentage of contracts included limits on drug
3 refills; is that correct?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: Correct.

6 BY MR. EHSAN:

7 Q. Number 11, certain percentage of contracts
8 had educational addiction risks and behaviors;
9 correct?

10 A. Yes.

11 Q. Is it fair to say that this publication was
12 available in 1999 to anyone with access to PubMed to
13 review?

14 MS. BALDWIN: Object to form and leading.

15 THE WITNESS: Yeah.

16 BY MR. EHSAN:

17 Q. The question is once the article is
18 published, doctor, is it your understanding that it
19 is readily available to anyone to access through the
20 National Institutes of Health Public Medicine
21 Library?

22 MS. BALDWIN: Object to form.

23 THE WITNESS: Yes.

24 BY MR. EHSAN:

25 Q. And, in fact -- back up and ask it this way:

1 What was your goal in identifying these facets of
2 various patient contracts at academic medical centers
3 in a publication?

4 A. Well, this is work that I think demonstrates
5 a very early commitment to pharmacovigilance and
6 again, you know, well before anyone was -- you know,
7 that this was in any way in the public media. In
8 fact, we were criticized for doing this work because
9 it was felt that these opioid contracts were somehow
10 in conflict with the doctor-patient trust
11 relationship, so -- but we did it because we felt
12 that these were going to be more and more required;
13 and I think we were prescient about that, that this
14 could have the potential to do a lot of good, but we
15 were worried that there might be elements that might
16 be viewed as harmful as well, and there had never
17 been an attempt to get consensus on what should be in
18 these agreements even though they were in fact widely
19 used.

20 So this is really the first time opioid
21 contracts, which were widely used in academic centers
22 and we believe probably widely used in private
23 centers as well, had been looked at with any kind of
24 scrutiny.

25 Q. So by 1997 when you began doing this work,

1 it is your understanding that there were opioid
2 contracts widely in use within the academic medical
3 centers?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: I believe that to be true.
6 And in the public sector as well.

7 BY MR. EHSAN:

8 Q. And, likewise, in 1997 when you were
9 conducting this research for this publication, your
10 understanding is that there were opioid contracts
11 widely in use within the private sector?

12 A. Correct.

13 MS. BALDWIN: Object to form.

14 BY MR. EHSAN:

15 Q. So if someone wanted to design an opioid
16 contract, this publication would provide a blueprint
17 upon which one could start the process; would that be
18 a fair statement?

19 MS. BALDWIN: Object to form. Leading.

20 THE WITNESS: Again, I would frame it that
21 this would help support the content that they could
22 use and, you know, essentially give them content that
23 they could decide to add or reject in their
24 contracts. I think we state in here that contract's
25 very individual and that, in fact, the contract -- I

1 don't know if we said this, I think I might have,
2 that, you know, there's never been a case where a
3 physician sued a patient for breaking the contract,
4 but patients have actually sued their physicians for
5 breaking their own contract. So it's important to
6 tailor it to your practice and then adhere to the
7 contract that you sign.

8 BY MR. EHSAN:

9 Q. Were some of the facets that were identified
10 in this publication in 1999 about patient contracts
11 been widely accepted in 2019 as best practices?

12 A. I believe so.

13 MS. BALDWIN: Object to form.

14 BY MR. EHSAN:

15 Q. Do you think that if -- strike that. Ask
16 the question differently.

17 Do you think that an adoption of a contract
18 like this, like -- strike that.

19 Do you believe that the adoption of
20 contracts such as those that you identified in this
21 paper would be helpful in reducing the potential risk
22 of abuse, misuse and addiction in patients prescribed
23 long-term opioid therapy?

24 MS. BALDWIN: Object to form.

25 THE WITNESS: Well, I'd like to say that at

1 the time that this was conducted, this study was
2 conducted, I don't know that you could support that a
3 contract was part of the standard of care. It now is
4 because it's recommended by the national and many,
5 many state guidelines for prescribing opioids.

6 Particularly, it's called for out of the CDC
7 guidelines, and it's called for in the FSMB
8 guidelines as well, so I'd go further, that it's
9 almost a required part of the safe process of
10 prescribing opioids.

11 BY MR. EHSAN:

12 Q. And that the requirement in 2019 was
13 available in the public domain, at least through your
14 publication, back in 1999; correct?

15 MS. BALDWIN: Object to form.

16 THE WITNESS: I don't think the requirement
17 was, but the resources were available to produce an
18 agreement that would have these elements.

19 BY MR. EHSAN:

20 Q. I am told that we have to stop here, so why
21 don't we take a break.

22 A. All right.

23 VIDEO OPERATOR: Okay. We're off the record
24 at 11:57.

25 (Noon recess taken)

1 VIDEO OPERATOR: Okay. We're back on the
2 record. It's 1:13.

3 BY MR. EHSAN:

4 Q. Dr. Fishman, before we went on break, we
5 were talking about your 1999 article regarding
6 various patient contracts in use at academic centers.
7 Do you recall that testimony?

8 A. I do.

9 Q. I think you testified that it has now become
10 standard of care to have patient contracts when
11 prescribing opioids. Did I recall that testimony
12 correctly?

13 A. Well, they're -- yes. They're often
14 referred to as agreements now or other euphemisms,
15 but they're, in my opinion, still contracts.

16 Q. To use your term, these patient agreements,
17 at least in California, how did they become the
18 standard of care if you know?

19 A. Well, I think that they became the standard
20 of -- well, the standard of care is -- as I
21 understand it from medical boards that have to
22 determine the standard of care, come from state and
23 national guidelines that -- from experts in the field
24 in which the standard would be derived, so over the
25 last ten years or so, there's been a steady growth of

1 guidelines around what is appropriate for pain
2 management, and I don't think there's been a
3 guideline that hasn't cited the use of the formal
4 agreement as a recognized part of a responsible
5 interaction or an interaction that would support
6 responsible opioid prescribing.

7 Q. So the states, in connection with consulting
8 with these experts, would have a part to play in
9 setting the standard of care for appropriate opioid
10 prescribing?

11 MS. BALDWIN: Object to the form.

12 THE WITNESS: I think they would argue they
13 don't set it, they determine it.

14 BY MR. EHSAN:

15 Q. So the states, in consultation with these
16 experts, would determine the standard of care for
17 practice of doctors; is that correct?

18 MS. BALDWIN: Object to the form and
19 leading.

20 THE WITNESS: Essentially. The board would
21 have to determine what the standard is, and they
22 determine that from experts as well as guidelines and
23 consensus materials that may have been developed.

24 BY MR. EHSAN:

25 Q. Talked about these state medical boards. Do

1 you recall that testimony?

2 A. To some degree.

3 Q. And these state medical boards, they are, at
4 least in California, part of the State of California;
5 is that correct?

6 MS. BALDWIN: Object to the form.

7 THE WITNESS: The medical board of
8 California is the only medical board of California
9 for M.D. physicians, and they're part of the state
10 government.

11 BY MR. EHSAN:

12 Q. Right. So to ask the question even more
13 generally, in order to prescribe -- I'll step back
14 again. Strike that.

15 In order to practice medicine in the State
16 of California, you need a license; correct?

17 A. In the vast majority of cases. There are
18 circumstances where you don't.

19 Q. And the person who bestows that license upon
20 a healthcare professional is the State of California;
21 correct?

22 A. That is correct.

23 MS. BALDWIN: Object to the form. Leading.

24 BY MR. EHSAN:

25 Q. And that's actually embodied in state

1 regulations; correct?

2 MS. BALDWIN: Object to the form. Leading.

3 THE WITNESS: It's the law.

4 BY MR. EHSAN:

5 Q. And part of the practice of medicine is the
6 ability to prescribe medications; correct?

7 MS. BALDWIN: Object to the form. Leading.

8 THE WITNESS: Correct.

9 BY MR. EHSAN:

10 Q. So the State of California not only empowers
11 you, Dr. Fishman, to practice medicine, but it also
12 empowers you to prescribe medications; correct?

13 MS. BALDWIN: Object to the form. Leading.

14 THE WITNESS: I could not prescribe
15 medications without a state medical license.

16 BY MR. EHSAN:

17 Q. So the State can put certain restrictions on
18 how to practice medicine; correct?

19 MS. BALDWIN: Object to the form and
20 leading.

21 THE WITNESS: They can and they do.

22 BY MR. EHSAN:

23 Q. What kind of restrictions are on your
24 ability to practice medicine put forth by the State
25 of California?

1 A. Well, there are many different rules I have
2 to follow. Just the ones that come to mind around
3 opioids that I have to check are prescription
4 monitoring program. They can put limits on how much
5 I can prescribe over a limited amount of time. The
6 kind of paper I have to use to be able to write a
7 prescription has been something that's been required
8 in California for many, many years and has changed
9 over the years, things of that sort.

10 Q. Is it your understanding that the State of
11 California had this power over your -- to determine
12 how you practice medicine from the time you became
13 licensed in the State of California?

14 A. Again, I think it would be controversial to
15 use that language, that they have a power over the
16 way I practice medicine, but they do place limits and
17 parameters on my practice, and I did know that from
18 the time I entered the state and got my state
19 license.

20 Q. When did you get your license, medical
21 license in the State of California?

22 A. I think it was 1999.

23 Q. Was your experience in Massachusetts
24 different than your experience in California in terms
25 of the State having the ability to place limits on

1 your practice of medicine?

2 A. No.

3 Q. Is it fair to say in every state you
4 practice, the State has had some ability to limit how
5 you practice medicine?

6 MS. BALDWIN: Object to the form.

7 Are you talking about the states that he's
8 practiced?

9 BY MR. EHSAN:

10 Q. Answer the question if you understand.

11 A. So, yes, I think you're referring to states
12 I practice, and I would say yes. I'd also add that I
13 think that's true of every state medical board.

14 Q. Do you have any requirements in the State of
15 California to attend continuing medical education
16 programs?

17 A. Yes.

18 Q. And who determines the specifics of those
19 requirements?

20 A. So is your question about whether I'm
21 required by the state medical board to attend CME or
22 other -- there are many different requirements for
23 CME.

24 Q. Let's start with does the State of
25 California place any requirements for you to maintain

1 your medical license that involve attending
2 continuing medical education programs?

3 A. Yes. I have to have a number of CME credits
4 of certain kinds. There's also a requirement in pain
5 management in our state for new licensees to have --
6 I think it's 12 hours of pain and end of life
7 training.

8 Q. You anticipated my next question. Has the
9 State of California made any specific requirements as
10 it relates to continuing medical educations for those
11 who are prescribing opioids?

12 A. They have, but that was awhile ago, and it
13 was really in response to a concern about underuse of
14 opioids as opposed to overuse of opioids.

15 Q. Nevertheless, the State determined and put
16 in effect requirements for physicians to get educated
17 regarding opioids; is that correct?

18 MS. BALDWIN: Object to the form and
19 leading.

20 THE WITNESS: Again, not specific to opioids
21 but specific to pain and end of life care.

22 BY MR. EHSAN:

23 Q. Thank you for the clarification. So the
24 State put in continuing education requirements for
25 physicians related to pain management and end of life

1 care; correct?

2 MS. BALDWIN: Object to the form.

3 THE WITNESS: Yes.

4 BY MR. EHSAN:

5 Q. Are you aware of any reason why the State
6 couldn't put requirements for continuing medical
7 education programs related to the risks of opioids?

8 MS. BALDWIN: Object to the form.

9 THE WITNESS: I believe that they have
10 every -- they have the opportunity to do that. They
11 could do that.

12 BY MR. EHSAN:

13 Q. And do you think that would be helpful in
14 educating physicians about the risks of opioids in
15 their prescribing decisions?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: I think it would be helpful.

18 BY MR. EHSAN:

19 Q. Have you ever advocated for the State to
20 adopt formal education requirements related to the
21 risks of opioids like the ones you have provided to
22 your colleagues over the years?

23 A. I have.

24 Q. And has the State responded to any of that?

25 A. They have not adopted that practice.

1 Q. And your CME education programs highlighting
2 the risk of opioids, those go back to the '90's; is
3 that correct?

4 MS. BALDWIN: Object to the form.

5 THE WITNESS: Yes.

6 BY MR. EHSAN:

7 Q. When you prescribe medications for your
8 patients in clinic, and I'm talking about any
9 medication, are you sometimes limited in your options
10 by the particular coverage that the patient has? And
11 by "coverage," I mean insurance coverage.

12 A. Absolutely.

13 Q. So it would be fair to say that insurance
14 coverage can impact the options you have as a
15 prescriber in addressing your patient's concerns?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: Yes.

18 BY MR. EHSAN:

19 Q. Have you ever found it frustrating, in the
20 treatment of your patients who suffer from chronic
21 pain, that their insurance coverage wasn't as robust
22 as you would have liked it to be?

23 MS. BALDWIN: Object to the form.

24 THE WITNESS: Absolutely.

25 BY MR. EHSAN:

1 Q. Are there certain types of -- strike that.

2 Do you have any examples of those instances?

3 A. I would argue that I'm probably frustrated
4 by those limitations in most cases, largely because
5 people in chronic pain have much more than just pain.
6 They have years and years of deconditioning that have
7 occurred because of the effect of kind of having this
8 alarm that won't turn off, and that limits their
9 ability to function and stay conditioned physically,
10 psychologically, socially, etc. There are very few
11 insurance plans that cover the reconditioning that
12 most people need.

13 So I would say I'm intrinsically frustrated
14 almost in every case that people don't have the
15 resources they need, and I would argue that those
16 resources would be economically optimal relative to
17 the things that they -- the resources they wind up
18 wasting. You know, we would cost recover those
19 resources if we gave them to patients, but they're
20 usually not available.

21 Q. You mentioned that you had to check the
22 prescription drug monitoring program as part of your
23 prescribing of opioids. Do I recall that testimony
24 correctly?

25 A. Yes.

1 Q. What is a prescription drug monitoring
2 program?

3 A. Prescription drug monitoring program is a
4 state-based program that keeps track of the
5 controlled substances that are being prescribed from
6 the point of care of the prescriber to the pharmacy
7 and tries to give -- well, they're used for two
8 purposes; one for law enforcement purposes and the
9 other for clinical purposes.

10 On the clinical side, it offers a view for
11 the clinician to see where their patient -- what
12 medications -- what controlled substances their
13 patients are getting and where they're getting them
14 from, and then it offers a database for law
15 enforcement to use that data for whatever purposes
16 they want to use it for.

17 Q. Do you know when California's prescription
18 drug monitoring program went into effect?

19 A. Well, I wrote a long article on that
20 subject, but it's debated that California is the
21 oldest prescription drug monitoring system in the
22 country. It's contentious between California and
23 Texas, but I think it went into effect a long time
24 ago, and I want to say in the '40's. It was the
25 first paper-based prescription drug monitoring

1 system. So we've had a system here for a long time.
2 I can't give you the exact date.

3 Q. Certainly by the 1990's, that prescription
4 drug monitoring program was in place in California;
5 is that correct?

6 A. Well, it was still the same -- by the
7 1990's, it was still the same triplicate-based,
8 paper-based system, and then it changed in the early
9 2000's to an electronic-based system that was, I
10 think, much more rational.

11 Q. So it digitized -- or went digital sometime
12 in the 2000's?

13 A. Correct.

14 Q. Do you have a more precise date in mind?

15 A. I don't. I actually did the -- I did the
16 press conference with Jerry Brown announcing that,
17 and I would argue it may have been 2006, 2007 if I --
18 and we spent a lot of time arguing in the state
19 legislature that it was a better system.

20 It took a lot of work to sway law
21 enforcement to give up this triplicate system that we
22 had that we thought was nonoptimal if not
23 deleterious.

24 Q. I want to hand -- if I could have you look
25 at what was previously marked Exhibit 26 to your

1 deposition.

2 A. It's the excerpt --

3 Q. You have good memory, recall. Thank you.
4 Because multiple copies have been spoke of, now gone
5 into the record, I just want to clean up some facts
6 here.

7 A. Uh-huh.

8 Q. If you look at what was marked as
9 Exhibit 26, which was an excerpt of your book that
10 the State put in front of you, do you see that it
11 bears the copyright of 2007 on page three of the
12 exhibit?

13 A. I do.

14 Q. Now you mentioned somewhere along the way
15 that the actual copy of the book had a forward by
16 someone who then went on to become attorney general
17 of the State; correct? Or sorry. Surgeon General
18 of the United States.

19 A. Correct.

20 Q. Do you know, can you tell if this is that
21 copy or a different copy of the book?

22 A. The first forward was by Regina Benjamin.

23 Q. Okay.

24 A. And she went on to be Obama's first Surgeon
25 General.

1 Q. Yeah.

2 A. And --

3 Q. So if I have you look at the third page from
4 the back of the exhibit, you will see there is a
5 contents list.

6 A. Yeah.

7 Q. And on the forward, it says "By Homan
8 Chaudhry, DO FACP." Do you see that?

9 A. Dr. Chaudhry --

10 Q. Okay. Sorry.

11 A. -- went on to become president/CFO of the
12 FSMB, so she wrote the first forward. This is not
13 actually -- this is the first edition, but this is
14 not the first printed of the first edition. Okay.

15 So when she became Surgeon General and was
16 no longer -- Regina Benjamin was chair of the
17 Federation of State Medical Boards, we had the
18 president/CEO take over that writing of the forward.

19 Q. Okay. So I think you may have clarified my
20 confusion. So this is the first edition but not the
21 first printing of the first edition?

22 A. That's what it appears to me. And
23 Dr. Chaudhry was not actually president/CEO at the
24 time that the book was written or the first
25 publication was made.

1 Q. Very good. I just wanted to clarify why
2 this forward was by a different person than you had
3 mentioned --

4 A. Got it.

5 Q. -- before. Now in focusing on this book in
6 2007, I think you had said that part of the impetus
7 for the book was to impart upon the physician
8 community that a greater vigilance was needed in
9 terms of use of opioids. Do you recall that
10 testimony?

11 A. I do.

12 Q. Now is that greater vigilance, just in your
13 mind, restricted to only the prescribers, or did you
14 think that that vigilance needed to be also exercised
15 by the state medical boards?

16 MS. BALDWIN: Object to form.

17 THE WITNESS: I think the vigilance is
18 required by the prescribers, but I think there's a
19 lot of nuance that the medical boards need to
20 understand when they review physicians who are --
21 have their practices contested and are -- come
22 under -- trying to find the word -- when they're
23 charged with something by the medical board.

24 So my worry is that medical boards wouldn't
25 understand what's really required and maybe would

1 miss prescribers who really are practicing beneath
2 the standard of care, or they would see that there
3 were problems with prescriptions but really
4 understand that some physicians are out there trying
5 to do the very best they can in following these --
6 this kind of guidance which is imperfect. You know,
7 it's not a perfect science. And understand their
8 practices in that light.

9 So while the pharmacovigilance is really for
10 the physicians, I think it still helped education the
11 medical boards.

12 BY MR. EHSAN:

13 Q. Do you think pharmacovigilance was also
14 useful to be exercised by P&T committees?

15 (Discussion off the record)

16 THE WITNESS: By pharmacy and therapeutic --

17 MR. EHSAN: That's correct.

18 THE WITNESS: -- committees who determine
19 what drugs are going to put on.

20 (Discussion off the record)

21 MS. BALDWIN: Objection to the form.

22 THE WITNESS: So this is pharmacy and
23 therapeutic committees that determine the drug
24 contents of hospital formularies or health system
25 formularies. You know, I'm not sure, but I can only

1 imagine it would inform them on some level about the
2 appropriate use of drugs.

3 BY MR. EHSAN:

4 Q. You mentioned that the insurance coverage
5 can sometimes be a frustration for you. Can the
6 formulary options available to you for a given
7 patient also cause you consternation under some
8 circumstances?

9 MS. BALDWIN: Object to the form.

10 THE WITNESS: Absolutely. There are, you
11 know, really good examples where clinicians have had
12 to choose less than optimal, less safe options for
13 their patients because the safer options aren't
14 covered or weren't under formulary.

15 Probably the best example is methadone which
16 is, you know, an effective opioid for pain but is
17 probably the most lethal of all of our opioids.
18 Problem is it's the least expensive of all of our
19 opioids as well, so it would always be the last
20 opioid standing on the formulary, and many physicians
21 had to choose it because they didn't have other
22 choices.

23 BY MR. EHSAN:

24 Q. Are you aware of the fact that methadone
25 causes disproportionate number of deaths related to

1 opioids relative to the number of prescriptions
2 written for it?

3 MS. BALDWIN: Object to the form. Leading.

4 THE WITNESS: I'm aware that it accounts for
5 about two to three percent of the prescriptions and
6 somewhere around 25 to 30 percent of the unintended
7 overdose deaths.

8 BY MR. EHSAN:

9 Q. Is it your understanding that was maintained
10 on many formularies because of the fact it was cheap?

11 A. Yes. I think that's what I'd said.

12 Q. You can put that exhibit aside. Thank you
13 for the clarification, Doctor.

14 Earlier today, you were asked some questions
15 about the sources of information that prescribers use
16 in understanding the risks and benefit of the
17 medications that they prescribed. Do you recall that
18 testimony?

19 A. I do.

20 Q. And I think you said that there were
21 multiple sources available to the physician; is that
22 correct?

23 A. Yes.

24 Q. And would one of those sources be the
25 prescribing information or drug label for the

1 medication?

2 A. Absolutely.

3 Q. And I believe you testified, but I'll ask
4 you the question anyway, and you agree, doctor, that
5 at a minimum, a doctor should be aware of what's in
6 the drug label the medication he or she is going to
7 prescribe?

8 A. Yes.

9 MS. BALDWIN: Object to the form. Leading.

10 THE WITNESS: Yes.

11 BY MR. EHSAN:

12 Q. Have you ever prescribed scheduled drug for
13 which you hadn't read the label?

14 A. It's hard to answer that. Probably.

15 Q. Let me strike it and ask the question
16 slightly differently because the question was broad.

17 Is it your practice to read the label of
18 medications that you're going to prescribe to your
19 patients?

20 A. Yes.

21 Q. Specific as to opioid, was it your practice
22 to read the labeling for those medications when you
23 prescribed that for your patients?

24 MR. ZAKRZEWSKI: Objection to form.

25 MR. ERCOLE: I'll reask the question.

1 BY MR. EHSAN:

2 Q. As specific to opioid, was it your practice
3 to be aware of the contents of the label for
4 medicines, opioid medicines that you prescribed to
5 your patients?

6 MS. BALDWIN: Object to the form.

7 THE WITNESS: Yes.

8 BY MR. EHSAN:

9 Q. And would you consider that to be good
10 clinical practice?

11 A. I would say it's good clinical practice.
12 There are many ways to know the content of the label
13 rather than the label itself, but yes.

14 Q. Yes, and I appreciated that in my broad
15 question, that you may be aware of the contents of
16 the label without having read the label itself;
17 correct?

18 A. Correct.

19 MS. BALDWIN: Object to the form.

20 BY MR. EHSAN:

21 Q. And, in fact, the label is based on
22 scientific data gathered by the company and submitted
23 to the Food and Drug Administration; correct?

24 MS. BALDWIN: Object to the form.

25 THE WITNESS: Correct.

1 BY MR. EHSAN:

2 Q. And that underlying data, for the most part,
3 is available within the medical literature; is that
4 correct?

5 MS. BALDWIN: Object to the form.

6 THE WITNESS: Correct. And many of us use
7 secondary resources that clearly incorporate the
8 label.

9 BY MR. EHSAN:

10 Q. And especially more recently, there has been
11 lots of other third parties that have collected that
12 information from the label into more readily
13 accessible format; is that correct?

14 MS. BALDWIN: Object to the form.

15 THE WITNESS: Absolutely.

16 (Exhibit 40 marked)

17 BY MR. EHSAN:

18 Q. Dr. Fishman, I've handed you what's been
19 marked Exhibit 40. I'll ask you if you've ever seen
20 this document before, maybe not in this exact format,
21 but the content of the document.

22 A. I've seen a label for the Duragesic product
23 before.

24 Q. And I will represent to you that this is the
25 Duragesic label approved by the Food and Drug

1 Administration in 2005, and if you look at the very
2 last page of the exhibit, you will see that it was
3 electronically signed for Bob Rappaport, who was at
4 the FDA, on February 4th, 2005. Do you know who
5 Dr. Rappaport is?

6 A. I do.

7 Q. Was he at the FDA?

8 A. Yes.

9 Q. Okay. Realizing that this is a label for a
10 medication, I understand that aspect, but I want to
11 ask you some questions generally about the labels for
12 opioid medication using this particular label as an
13 example. Are you aware of what a black box is?

14 A. I am.

15 Q. And what is a black box?

16 A. Black box is a highly-emphasized
17 contraindication. It's a full stop.

18 Q. And you notice in the beginning of this
19 particular label, there is literally a dark box
20 surrounded by bolded text; is that correct?

21 A. Yes.

22 Q. And that would be consistent, it's your
23 understanding, of what a black box warning looks
24 like?

25 A. Yes.

1 Q. Now looking at the box warning, this is the
2 first thing you see when you actually look at the
3 label for this particular drug; is that correct?

4 MS. BALDWIN: Object to the form.

5 THE WITNESS: Yes.

6 BY MR. EHSAN:

7 Q. And it's intended to have a prominent view
8 when the physician looks at the label. Is that
9 consistent with your understanding?

10 MS. BALDWIN: Object to the form.

11 THE WITNESS: It's the equivalent of a big
12 exclamation sign.

13 BY MR. EHSAN:

14 Q. Now looking specifically at this box
15 warning, can you read the first paragraph inside the
16 box warning, please?

17 A. "Duragesic contains a high concentration of
18 potent Schedule II opioid agonist, fentanyl.
19 Schedule II opioid substances, which include
20 fentanyl, hydromorphone, methadone, morphine,
21 oxycodone and oxymorphone, have the highest potential
22 for abuse and associated risk of fatal overdose due
23 to respiratory depression. Fentanyl can be abused
24 and is subject to criminal diversion. A high content
25 of fentanyl in the patches may be a particular target

1 for abuse and diversion."

2 Q. Thank you, Doctor. Is there anything
3 inaccurate about the statement that you just read?

4 A. No.

5 Q. Do you think it adequately --

6 MS. BALDWIN: Object to the form.

7 BY MR. EHSAN:

8 Q. Based on your understanding of the risks
9 associated with fentanyl, do you think it adequately
10 reflects the potential risk for abuse associated with
11 a fentanyl-based product?

12 MS. BALDWIN: Object to the form.

13 THE WITNESS: Yes.

14 BY MR. EHSAN:

15 Q. And it goes beyond just fentanyl. It
16 identifies several other types of opioid substances;
17 is that correct?

18 A. That is correct.

19 Q. It includes oxycodone; correct?

20 A. Yes.

21 Q. Do you recall yesterday you were shown some
22 material that suggested -- or excuse me -- an
23 internal Purdue email that suggested that somehow
24 some people think of oxycodone as a weak opioid?

25 MS. BALDWIN: Object to the form,

1 mischaracterizes the email.

2 BY MR. EHSAN:

3 Q. Do you recall that testimony?

4 A. I do.

5 Q. This particular label doesn't identify
6 oxycodone as a weak opioid, does it?

7 A. No.

8 MS. BALDWIN: Object to the form.

9 BY MR. EHSAN:

10 Q. And, in fact, it says both fentanyl and
11 oxycodone have the highest potential for abuse; is
12 that correct?

13 A. Yes.

14 Q. And also the highest potential for
15 associated risk of fatal overdoses; correct?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: Yes.

18 BY MR. EHSAN:

19 Q. Now if a physician were to look at the label
20 for this particular product, he or she would have the
21 opportunity to read that for him or herself; correct?

22 A. That is correct.

23 Q. Now if you go down to -- by the next bullet
24 that has two sub bullets, but the paragraphs below
25 that, we're still in the box warning, you see there

1 that it states that "Duragesic should only be used
2 for patients who are already receiving opioid therapy
3 and have demonstrated opioid tolerance and who
4 require total daily dose at least equivalent to
5 Duragesic at 25 micrograms per hour"?

6 A. I do see that.

7 Q. So, doctor, would it be fair to say that
8 patients who are receiving Duragesic would be
9 patients who are --

10 (Discussion off the record)

11 BY MR. EHSAN:

12 Q. As a clinician who prescribes -- strike
13 that. Let me back up.

14 Have you prescribed Duragesic before in your
15 career?

16 A. I have.

17 Q. As a physician who's prescribed Duragesic in
18 the past, would you interpret that statement to mean
19 that patients who are going to be receiving Duragesic
20 would have already been on an opioid medication prior
21 to their Duragesic prescription?

22 MS. BALDWIN: Object to the form.

23 THE WITNESS: Not only that they would have
24 been on an opioid, but they would have to have been
25 on a substantial amount of an opioid, substantial

1 dose.

2 BY MR. EHSAN:

3 Q. So in that way, those patients have
4 already -- strike that. Let me ask the question
5 differently.

6 Duragesic would not be the first line opioid
7 therapy for a patient; is that correct?

8 MS. BALDWIN: Object to the form.

9 THE WITNESS: Correct.

10 BY MR. EHSAN:

11 Q. And presumably, if those patients were
12 already on a substantial dose of opioids, a physician
13 had determined some point in the past that opioid
14 medications were an appropriate choice for that
15 patient; is that correct?

16 MS. BALDWIN: Object to the form and
17 leading.

18 THE WITNESS: Yes.

19 BY MR. EHSAN:

20 Q. And would it be fair to say that if you had
21 a patient on an opioid medication for where the
22 opioid medication wasn't helping the patient, you
23 would not switch them to Duragesic but rather try to
24 discontinue the opioid medication?

25 MS. BALDWIN: Object to the form.

1 THE WITNESS: Well, I think there might be
2 some cases where the opioid's not helping for
3 idiosyncratic reasons related to the individual
4 properties of an opioid; say they had an intolerance,
5 you know, morphine caused a rash and they were on
6 enough morphine that it would warrant changing to
7 options that might include the fentanyl patch, then
8 possibly.

9 Fentanyl has -- the fentanyl patch has some
10 advantages, but it has many disadvantages as well,
11 and those would need to be, you know, carefully
12 considered in an individual patient. So there might
13 be a case where in fact that's not true. Most of the
14 time, what you said is true.

15 BY MR. EHSAN:

16 Q. And I appreciate the nuance, the
17 consideration. I think I can ask this question more
18 simply.

19 If a patient is maintained on a substantial
20 dose of opioid therapy, thus qualifying them to meet
21 the requirements in the Duragesic label, it'd be a
22 fair assumption to say that the opioid medication
23 they're on has been working for them; is that
24 correct?

25 MS. BALDWIN: Object to the form.

1 THE WITNESS: Yes, but usually if the opioid
2 medication they're on is working for them, we keep
3 them on the medicine that's working for them, so
4 that -- yeah.

5 BY MR. EHSAN:

6 Q. Understood.

7 A. Yes.

8 Q. And there may be specific patient factors
9 that may warrant switching them from one opioid to
10 the Duragesic patch; correct?

11 A. Correct.

12 MS. BALDWIN: Object to the form.

13 THE WITNESS: Yes, correct.

14 BY MR. EHSAN:

15 Q. And the Duragesic patch has a different
16 delivery mechanism than oral opioid medications;
17 correct?

18 A. Yes.

19 Q. What is the delivery mechanism for the
20 Duragesic patch?

21 A. It's a transdermal system where the
22 medication passes through the skin into the fat
23 tissue and then slowly is absorbed into the
24 circulation through that depot of opioid.

25 Q. And that represents certain advantages and

1 certain disadvantages; correct?

2 A. Yes.

3 MS. BALDWIN: Object to the form.

4 THE WITNESS: Exactly.

5 BY MR. EHSAN:

6 Q. And depending on the specific needs of the
7 patient, those advantages may be attractive, or those
8 disadvantages may be preclusive of prescribing a
9 Duragesic patch for a patient; correct?

10 MS. BALDWIN: Object to the form.

11 THE WITNESS: Absolutely.

12 BY MR. EHSAN:

13 Q. Now if you go to the next section, still the
14 same page, first page of the box warning, this one is
15 now the underlying material, so it's bolded and
16 underlined, and it says "Because serious or
17 life-threatening hypoventilation can occur, Duragesic
18 fentanyl transdermal system is contraindicated,"
19 colon. Do you see that?

20 A. Yes.

21 Q. And could you read those contraindications?

22 A. "In patients who are not opioid-tolerant; in
23 the management of acute pain or in patients who
24 require opioid analgesia for a short period of time;
25 in the management of postoperative pain, including

1 use after outpatient or day surgeries; in the
2 management of mild pain; in the management of
3 intermittent pain, e.g., use on an as needed basis or
4 prn."

5 Q. Would it be fair to say, doctor, that if a
6 prescriber prescribed Duragesic patch for any of the
7 conditions listed here, that they would be
8 prescribing the medication contrary to what the label
9 recommends?

10 A. Or what we would call off label, yes.

11 Q. In the case of prescribing a medication off
12 label, is it even more important for the physician to
13 understand the risks and benefits of the medication
14 he or she is prescribing?

15 A. I would say if you're going to prescribe a
16 medicine off label, you have to understand the risks
17 and benefits very, very well and make a very clear,
18 transparent risk benefit analysis-based decision.

19 Q. Go to the next page. You see that the box
20 warning continues on the second page; is that
21 correct?

22 A. I do.

23 Q. About halfway down, there's a -- there's a
24 lot of underlining here, too, but it begins with the
25 underlined statement "Duragesic is only for use in

1 patients." Do you see that?

2 A. Yes.

3 Q. Do you see the -- can you read the
4 underlined two sentences and the sentence that comes
5 after it, please?

6 A. "Duragesic is only for use in patients who
7 are already tolerant to opioid therapy of comparable
8 potency. Use in nonopioid-tolerant patients may lead
9 to fatal respiratory depression. Overestimating the
10 Duragesic dose when converting patients from another
11 opioid medication can result in fatal overdose with
12 the first dose."

13 Q. Fair to say that's a pretty stern warning
14 that you have to know what you're doing with this
15 medication before you prescribe it?

16 A. Yes.

17 Q. And did you treat the patients you
18 prescribed Duragesic for with the same amount of
19 caution as this label indicates?

20 A. I believe I did.

21 Q. Nevertheless, there were patients for whom
22 you thought Duragesic was appropriate even in light
23 of these risks identified in this label; correct?

24 A. Yes.

25 Q. Will you read the next paragraph, please?

1 A. "Duragesic can be abused"?

2 Q. Yes, sir.

3 A. "Duragesic can be abused in a manner similar
4 to other opioid agonists, legal or illicit. The
5 risks should be considered when administering,
6 prescribing or dispensing Duragesic in situations
7 where the healthcare professional is concerned about
8 increased risk of misuse, abuse and diversion."

9 Q. Does that language clearly identify that the
10 abuse, misuse and diversion are risks associated with
11 the fentanyl patch?

12 MS. BALDWIN: Object to form.

13 THE WITNESS: I think it's a strong
14 statement and countermands a common belief that
15 because the -- it's a patch, it may be safer than a
16 pill.

17 BY MR. EHSAN:

18 Q. So focusing on this language here, this
19 label, this 2005 label predates the first edition of
20 your book; correct?

21 A. Yes.

22 Q. So would it be fair to say at least as of
23 the time you wrote your book, the drug labels for
24 these medications also reflected the level of caution
25 that you were espousing related to opioid medications

1 in your book?

2 MS. BALDWIN: Object to form and leading.

3 THE WITNESS: Yes.

4 BY MR. EHSAN:

5 Q. Going to the next paragraph, could you read
6 that, please? And I apologize. This will be the
7 last time I ask you to read something.

8 A. "Persons at increased risks for opioid abuse
9 include those with a personal or family history of
10 substance abuse, including drug or alcohol abuse or
11 addiction or mental illness; e.g., major depression.
12 Patients should be assessed for their clinical risks
13 for opioid abuse or addiction prior to being
14 prescribed opioids. All patients receiving opioids
15 should be routinely monitored for signs of misuse,
16 abuse and addiction. Patients at increased risk of
17 opioid abuse may still be appropriately treated with
18 modified release opioid formulations. However, these
19 patients will require intensive monitoring for signs
20 of misuse, abuse and addiction."

21 Q. Thank you, Doctor. That paragraph from
22 2005, is that still good advice today?

23 A. It is.

24 Q. Specifically, that language there doesn't
25 relate specifically to Duragesic, it talks about

1 opioids more generally; correct?

2 A. I think it applies to all opioids.

3 Q. So you would agree, then, even today, it
4 applies to all opioid-prescribing physicians?

5 MS. BALDWIN: Object to the form and
6 leading.

7 THE WITNESS: Yes.

8 BY MR. EHSAN:

9 Q. Would you agree, doctor, that personal or
10 family history of substance abuse is a key factor to
11 consider in the risk assessment for a particular
12 patient who might be prescribed opioids?

13 MS. BALDWIN: Object to the form.

14 THE WITNESS: Yes.

15 BY MR. EHSAN:

16 Q. In fact, having a personal family history of
17 substance abuse can greatly increase the individual's
18 potential risk for running into trouble with opioid
19 medication; correct?

20 MS. BALDWIN: Objection. Leading.

21 THE WITNESS: Yes.

22 BY MR. EHSAN:

23 Q. Likewise, a history of mental illness is a
24 factor that can change a particular patient risk
25 profile for developing a substance use disorder with

1 opioid medications; correct?

2 MS. BALDWIN: Objection. Leading.

3 THE WITNESS: Yes.

4 BY MR. EHSAN:

5 Q. And, obviously, these risks would have to be
6 assessed on a patient-by-patient -- sorry. Strike
7 that.

8 And these risks would have to be assessed on
9 a patient-by-patient assessment; correct?

10 MS. BALDWIN: Objection. Leading.

11 THE WITNESS: They would need to be assessed
12 individually patient by patient.

13 BY MR. EHSAN:

14 Q. No two patients are going to be alike;
15 correct?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: I agree.

18 BY MR. EHSAN:

19 Q. Do you think -- I think you mentioned that
20 risk benefit assessment is inherently a personal or
21 individualized decision, so thinking about that, do
22 you think that one can come up with a white line list
23 of diagnoses for which opioid medications would be
24 unnecessary?

25 MS. BALDWIN: Object to the form.

1 THE WITNESS: I want to clarify. It's a
2 personal decision for the patient, not for the
3 prescriber, and I don't know if there's a absolutely
4 single diagnosis that would exclude using an opioid
5 under some circumstance.

6 BY MR. EHSAN:

7 Q. And that was my question, so let me try also
8 asking it slightly different, in a slightly different
9 way.

10 When you assess a patient for pain therapy,
11 you are taking that patient in front of you and
12 assessing their individualized need exclusive of any
13 other -- strike that. Let me ask the question
14 slightly differently.

15 I think you said that you prescribe opioids
16 for a vast number of conditions. You recall that
17 testimony?

18 A. Yes.

19 MS. BALDWIN: Object to the form.

20 BY MR. EHSAN:

21 Q. So be fair to say that going into seeing a
22 patient, you do not have a preconceived notion
23 whether opioids are appropriate or inappropriate just
24 based on the diagnosis with which the patient
25 presents?

1 MS. BALDWIN: Object to the form and
2 leading.

3 THE WITNESS: Well, there's certain -- I
4 think what I said yesterday is I don't think anyone
5 should be for or against opioids, so -- but there are
6 certain conditions in which you'd have to reach a
7 very, very high bar to give an opioid to a patient,
8 so there's certain conditions where you'd walk in
9 thinking, "I'd really have to have proof here to use
10 an opioid" or, "I'd have to go through pretty
11 extraordinary pathway of reasoning to get to an
12 opioid as a possibility," you know, patients who have
13 had addiction, patients have pulmonary disease,
14 patients with severe mental illness. You're really
15 looking for every other option that would yield a
16 possible benefit, you know, outside of a palliative
17 care-type setting.

18 BY MR. EHSAN:

19 Q. And I appreciate that. So do I understand
20 you correctly you're saying that even in patients who
21 may have an opioid use disorder, you should not
22 blanketly exclude the possibility of using the
23 opioid, but the threshold for considering it would be
24 substantially higher? Is that correct?

25 MS. BALDWIN: Object to the form.

1 THE WITNESS: And many of these cases, an
2 opioid is indicated as maintenance therapy for their
3 opioid abuse problem.

4 BY MR. EHSAN:

5 Q. And, in fact, there are some opioids that
6 are used for the treatment of opioid use disorder;
7 correct?

8 MS. BALDWIN: Object to the form.

9 THE WITNESS: Correct. Better stated, yes.

10 BY MR. EHSAN:

11 Q. But my question was slightly difference, and
12 I apologize for not being clear about this.

13 Are there pain diagnoses that you could say,
14 based on the patient's pain diagnosis, "I am not
15 going to prescribe that patient an opioid"?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: I doubt it, but there are many
18 that I would be very, very hard-pressed, like, for
19 instance, migraine, to use an opioid because there's
20 evidence that suggests that while they may make
21 people feel better, they don't make them better, you
22 know, things of that sort, but there might be
23 extenuating circumstances in a given patient where
24 you might use it. It would be extraordinary, in my
25 practice, to give an opioid to someone with

1 migraines.

2 BY MR. EHSAN:

3 Q. Right. And that was the decision -- or my
4 attempt at the question was you wouldn't, just based
5 on that pain diagnosis, say, "There's no way I'm
6 going to prescribe you an opioid" but rather assess
7 the patient realizing that there may be much more
8 appropriate options for a particular patient for a
9 particular condition; correct?

10 MS. BALDWIN: Object to the form and
11 leading.

12 THE WITNESS: So I think what you're getting
13 at is that each patient needs an individualized
14 assessment, and I don't walk in the room with a --
15 simply based on knowing a diagnosis with a conclusion
16 about what they need or don't need.

17 BY MR. EHSAN:

18 Q. And thinking about patients who have cancer
19 versus patients who have chronic noncancer pain, do
20 you believe that the pain experienced by cancer
21 patients is somehow more appropriate for therapy
22 versus the pain suffered by patients with chronic
23 noncancer pain?

24 MS. BALDWIN: Object to the form.

25 THE WITNESS: Well, this is a very profound

1 question you ask. I believe that there's no
2 difference between the pain in cancer and the pain in
3 other diseases. What's different about cancer is
4 that -- well, really two major things: Many patients
5 with cancer have terminal illnesses, so the risk
6 benefit analysis in those patients shift because of
7 the looming short lifespan that they might have. So
8 the urgency to treat might push you to take more
9 risks with your treatment than you would otherwise.
10 I think that's the key difference in how we treat
11 cancer.

12 But with that said, there's a social
13 difference as well in that there's not a single
14 guideline on the prescribing of opioids that
15 addresses dealing with cancer patients. They all
16 exclude them because it's almost a tabu subject. So
17 we actually are dealing with drug abuse in our cancer
18 population.

19 I just wrote an article on this subject this
20 year which is very concerning because cancer
21 patients, by virtue of having cancer and the meaning
22 that it has in society, are viewed by the medical
23 community as being a special population that doesn't
24 require the same amount of vigilance and potentially
25 a lower threshold for engaging with an opioid.

1 In fact, I've seen cancer patients who are
2 on opioids because their doctor thought they might
3 need them down the road, so they might as well get
4 them started, things that are crazy like that. Does
5 that answer your question?

6 BY MR. EHSAN:

7 Q. I think you answered the question, that you
8 need to be vigilant irrespective of whether a patient
9 is a cancer patient versus a chronic noncancer
10 patient, but my question was that -- and I think you
11 addressed it at the beginning, but my question was
12 the pain doesn't discriminate based on whether the
13 patient has cancer or noncancer pain; correct?

14 MS. BALDWIN: Object to the form and
15 leading.

16 THE WITNESS: It's pain. Patient has pain.
17 The context is what's different.

18 BY MR. EHSAN:

19 Q. Understood. And pain doesn't discriminate
20 based on the patient's socioeconomic status; correct?

21 MS. BALDWIN: Object to the form.

22 THE WITNESS: That is correct.

23 BY MR. EHSAN:

24 Q. And pain doesn't discriminate based on age,
25 although you may have comorbidities, depending on

1 your specific age, that may complicate the process;
2 correct?

3 MS. BALDWIN: Object to the form and
4 leading.

5 THE WITNESS: That's a harder one. There is
6 data that suggests that as we get older, we perceive
7 pain differently, but in general, I would say I
8 agree.

9 BY MR. EHSAN:

10 Q. So just as a intellectual proposition, there
11 is no reason, both in terms of willingness to treat
12 and need to be vigilant, between cancer and noncancer
13 pain; is that correct?

14 MS. BALDWIN: Object to the form and
15 leading.

16 THE WITNESS: Correct.

17 BY MR. EHSAN:

18 Q. Dr. Fishman, do you know what the word
19 "doctor" means in Latin?

20 A. I do not.

21 Q. Okay. Would it surprise you to -- for me to
22 tell you that in Latin, the word means teacher?

23 A. Means teacher?

24 Q. Yes. That was my -- would that surprise
25 you, doctor?

1 A. Doesn't surprise me, but I didn't know that.
2 It's impressive.

3 Q. In fact, you've dedicated most, if not all,
4 your academic life to teaching; is that correct?

5 A. Yes.

6 Q. You've taught medical students?

7 A. Yes.

8 Q. You've taught residents?

9 A. Yes.

10 Q. You've taught fellows?

11 A. Yes.

12 Q. Just so that the record is clear, fellows
13 are people -- are doctors who have finished their
14 residency and doing additional educational training;
15 is that correct?

16 A. Yes.

17 MS. BALDWIN: Object to the form. Leading.

18 BY MR. EHSAN:

19 Q. And you teach fellow doctors; is that
20 correct?

21 MS. BALDWIN: Object to the form. Leading.

22 THE WITNESS: Practicing clinicians, yes.

23 BY MR. EHSAN:

24 Q. And throughout all of that education, has it
25 been your endeavor to ground your teachings in the --

1 strike that.

2 In your educational endeavors, have you
3 attempted to ground your teachings in science?

4 A. Yes.

5 Q. And obviously -- strike that.

6 Do you agree with the concept that science
7 evolves over time?

8 MS. BALDWIN: Object to the form.

9 THE WITNESS: Yes.

10 BY MR. EHSAN:

11 Q. For example, when penicillin was discovered
12 a hundred years ago, it had much broader applications
13 in the treatment of infections than it does today;
14 correct?

15 A. Yes.

16 MS. BALDWIN: Object to the form. Leading.

17 BY MR. EHSAN:

18 Q. However, today, we have scientific evidence
19 to judge a prescribing decision going back 50 or
20 60 years; correct?

21 MS. BALDWIN: Object to the form. Leading.

22 THE WITNESS: I'm sorry. Can you restate
23 that?

24 BY MR. EHSAN:

25 Q. Sure. Would it be fair to say that you

1 can't judge a medical decision made 50 years ago
2 based on the current state of science?

3 MS. BALDWIN: Object to the form. Leading.

4 THE WITNESS: I think you can. It wouldn't
5 be appropriate.

6 BY MR. EHSAN:

7 Q. You could do it, but it wouldn't be
8 appropriate?

9 A. Think it happens more than we like.

10 Q. So it is important that whenever one is
11 looking at historical educational programs, to tie
12 those back to the science that was available at the
13 time; correct?

14 MS. BALDWIN: Object to the form and
15 leading.

16 THE WITNESS: I agree.

17 BY MR. EHSAN:

18 Q. So you may have said some things differently
19 20 years ago that you said today, but regardless,
20 those have always been consistent with the science
21 available at the time; correct?

22 MS. BALDWIN: Object to the form and
23 leading.

24 THE WITNESS: I would say that there's much
25 that I would do differently now based on what I know

1 now that wasn't known then and that I still would
2 stand by what I've said and done based on my goal to
3 use what we have at hand to improve safety and
4 efficacy in practice.

5 BY MR. EHSAN:

6 Q. When you were in medical school, did you
7 take a pharmacology class?

8 A. I did.

9 Q. Were you taught about the mechanism of
10 action for opioid medications?

11 A. Very briefly.

12 Q. Did you understand them to affect the
13 mu receptor in the brain and spinal cord?

14 A. I did.

15 Q. Were you aware that opioid medications fall
16 into -- at the time, fell into the category of full
17 mu agonists and partial mu agonist?

18 MS. BALDWIN: Object to the form.

19 THE WITNESS: I did at the time.

20 BY MR. EHSAN:

21 Q. And a full mu agonist could reach the
22 maximal potency, you just have to change up the dose,
23 whereas a partial mu agonist had a cap on the effect
24 on the mu receptor; correct?

25 A. Yes.

1 MS. BALDWIN: Object to the form and
2 leading.

3 BY MR. EHSAN:

4 Q. Did you understand oxycodone to be a full
5 mu agonist?

6 A. Yes.

7 Q. Did you understand morphine to be a full
8 mu agonist?

9 A. Yes.

10 Q. Did you understand fentanyl to be a full
11 mu agonist?

12 A. Yes.

13 Q. So all those medications could reach full
14 potency just by increasing the dose; correct?

15 MS. BALDWIN: Object to the form and
16 leading.

17 THE WITNESS: Correct.

18 BY MR. EHSAN:

19 Q. Did you understand that the mu receptor also
20 played a role in the brain dopamine pathways?

21 A. Not as a medical student.

22 Q. When you were going through medical school,
23 what was the general attitude towards the prescribing
24 of opioids to pain patients regardless of whether
25 they were cancer or noncancer patients?

1 A. I went to medical school in the second half
2 of the '80's, and it was a time where there was a
3 Renaissance in using opioids for cancer, and then
4 this period of extrapolation to that experience and
5 the experience of people with chronic pain.

6 So it was a transitional time where I think
7 some people thought it was -- they were drugs that
8 were tabu, and others thought that it was a fantastic
9 opportunity to give them to anyone who said, "Ouch."

10 Q. So there were certainly folks -- strike
11 that.

12 There were certainly practicing physicians
13 who you interacted with, when you were a medical
14 student, who believed that opioids should not be used
15 in the treatment of pain unless in rare
16 circumstances; is that correct?

17 A. Yes.

18 Q. And that was one source of teaching you
19 received while you were in medical school; is that
20 correct?

21 A. Yes.

22 Q. I'm going to show you what's been --

23 MR. OXLEY: Could we just have a quick time
24 check?

25 MR. ZAKRZEWSKI: Yeah. Sure.

1 VIDEO OPERATOR: Oh.

2 MR. EHSAN: Yeah. Go ahead. How long have
3 we been on the record?

4 VIDEO OPERATOR: On the record?

5 THE WITNESS: While we're doing that, could
6 I just grab some water?

7 MR. EHSAN: Sure. Go off the record.

8 MR. ZAKRZEWSKI: Let's take a break.

9 VIDEO OPERATOR: Two hours and 38 minutes.

10 (Discussion off the record)

11 VIDEO OPERATOR: We're off the record. It's
12 2:08.

13 (Recess)

14 VIDEO OPERATOR: Okay. Back on the record.
15 It's 2:28.

16 BY MR. EHSAN:

17 Q. Dr. Fishman, you've been handed what's been
18 previously marked as Exhibit 21. Do you recall
19 talking about or being asked about questions about
20 this document yesterday?

21 A. I do.

22 Q. I just want to draw your attention to the
23 second page which is the first page with any
24 substantive content. Do you see that it's a Nucynta
25 Immediate Release Tapentadol Launch Plan?

1 A. Yes.

2 Q. Do you appreciate that the word -- that
3 "Nucynta" is misspelled?

4 MS. BALDWIN: Object to form.

5 THE WITNESS: I didn't.

6 BY MR. EHSAN:

7 Q. You didn't appreciate that?

8 A. I did not.

9 Q. Did you also see below it, it says
10 "Confidential Draft for Internal Review"?

11 A. Yes.

12 MS. BALDWIN: Object to form.

13 BY MR. EHSAN:

14 Q. When you were asked questions about this,
15 did you appreciate that this was a draft document?

16 MS. BALDWIN: Object to form. Leading.

17 THE WITNESS: I think I mentioned it at the
18 time. I really don't know the context of what this
19 is or how it would be used.

20 BY MR. EHSAN:

21 Q. Would you agree with me, doctor, that you
22 weren't shown any final version of this document? Is
23 that correct?

24 MS. BALDWIN: Object to form. Leading.

25 THE WITNESS: It appears that way.

1 BY MR. EHSAN:

2 Q. And based on a draft, you have no way of
3 knowing what, if any, final draft would have
4 contained the same or different language as contained
5 in this document; correct?

6 MS. BALDWIN: Object to the form. Leading.

7 THE WITNESS: Yes.

8 BY MR. EHSAN:

9 Q. You can put that one aside.

10 If you could take a look at Exhibit 5.

11 MR. ZAKRZEWSKI: 5?

12 MR. EHSAN: Yes. Thank you.

13 MS. BALDWIN: Would you mind? Thank you.

14 BY MR. EHSAN:

15 Q. Do you remember being shown this document
16 yesterday?

17 A. Yes.

18 Q. You notice "Nucynta" is spelled differently
19 in this document than the prior one we looked at;
20 right?

21 A. Yes.

22 MS. BALDWIN: Object to form.

23 THE WITNESS: Has a "Y."

24 BY MR. EHSAN:

25 Q. Yes. And I'll represent to you that's the

1 correct spelling of the branded medication.

2 MS. BALDWIN: Object to form.

3 BY MR. EHSAN:

4 Q. Do you know -- or strike that.

5 Are you aware that Nucynta has a dual
6 mechanism action?

7 A. I am.

8 Q. It's a opioid agonist as well as a
9 norepinephrine reuptake inhibitor; correct?

10 MS. BALDWIN: Object to the form. Leading.

11 THE WITNESS: I'm aware of that.

12 BY MR. EHSAN:

13 Q. So would it be fair to say that education
14 related to that particular dual mechanism of action
15 may allow certain physicians to consider prescribing
16 it as opposed to just thinking it's another "me too"
17 opioid?

18 MS. BALDWIN: Object to form. Leading.

19 THE WITNESS: I think it's critical to know,
20 to understand the dual mechanism that distinguishes
21 this drug from almost all other opioids.

22 BY MR. EHSAN:

23 Q. And specifically, there was some suggestion
24 that physician education, if you look at page eight
25 of that document -- wait till you're there.

1 A. I'm there.

2 Q. "Physician speaker programs often trigger
3 first use." Do you see that?

4 A. Yes.

5 Q. And would it be fair to say that if you are
6 educating someone about the dual mechanism of
7 Nucynta, it may allow that physician to consider that
8 in making that prescribing decision for other
9 patients? Correct?

10 MS. BALDWIN: Object to form and leading.

11 THE WITNESS: I think I mentioned this
12 yesterday, that I think prescriber decisions based on
13 speaker's program may be good or bad, and there are
14 times where the decisions are made because they now
15 have the full information appropriately.

16 BY MR. EHSAN:

17 Q. Correct. And so it's not necessarily bad
18 that an education program will allow a physician to
19 make a prescribing decision for a new drug that has a
20 different mechanism action; correct?

21 MS. BALDWIN: Object on form and leading.

22 THE WITNESS: Correct.

23 BY MR. EHSAN:

24 Q. If you could take a look at Exhibit 6. This
25 is an email and an attachment that was provided with

1 the email. Do you recall being asked questions about
2 this exhibit yesterday?

3 A. I do.

4 Q. I think you testified that the KOLs were
5 classified based on their -- based on their
6 publication as one factor. Do you recall that?

7 A. Yes.

8 Q. And there were also surveys of other
9 physicians to identify which specialists were
10 considered influential within the prescribing
11 community. Do you recall that?

12 A. I do.

13 MS. BALDWIN: Object to the form.

14 BY MR. EHSAN:

15 Q. And is it true that your -- strike that.

16 Is it true that a physician's volume of
17 prescribing can provide a source of information about
18 practical experience with a drug that may be of
19 benefit to other practicing physicians?

20 MS. BALDWIN: Object to form and leading.

21 THE WITNESS: I'm not sure I would agree
22 with that.

23 BY MR. EHSAN:

24 Q. Do you agree that someone who is published
25 within a field may have information that he or she

1 can share with fellow prescribing physicians?

2 MS. BALDWIN: Object to the form and
3 leading.

4 THE WITNESS: "May" is the key word, but
5 yes.

6 BY MR. EHSAN:

7 Q. There is nothing inherently problematic with
8 identifying physicians who may have clinical
9 experience, publication experience or other
10 experience with a particular medication to serve as
11 educators for other prescribing physicians. Would
12 you agree with that?

13 MS. BALDWIN: Object to the form and
14 leading.

15 THE WITNESS: I think that people who are
16 published, people who are in the academic arena,
17 people who are teaching and known to others, these
18 are all sources of respect that is engendered and why
19 people would think of them as knowledge leaders, so I
20 think those are all appropriate. I'm not sure about
21 number of prescriptions.

22 BY MR. EHSAN:

23 Q. Well, do you agree with me that part of the
24 information you draw upon in assessing the risk and
25 benefit of any particular medication is your personal

1 history with that medication in your patient
2 population?

3 A. Yes.

4 MS. BALDWIN: Object to the form and
5 leading.

6 BY MR. EHSAN:

7 Q. So that form is a source of information for
8 you in making a prescribe --

9 MS. BALDWIN: Object to the form and
10 leading.

11 THE WITNESS: Yes.

12 BY MR. EHSAN:

13 Q. And would you see anything inherently wrong
14 with sharing that experience with the caveat that
15 it's your personal experience with other prescribers?

16 MS. BALDWIN: Object to the form.

17 THE WITNESS: I don't see anything wrong
18 with sharing it in that direction. I do find
19 something wrong with looking for high prescribers to
20 become -- to be put on a pedestal and viewed by
21 others.

22 BY MR. EHSAN:

23 Q. Understood. I may have misspoken.

24 A. Yeah.

25 Q. My sense was that the number of

1 prescriptions as a surrogate for how many times
2 you've seen patients get prescribed that medication
3 having information about how the particular
4 prescription's turned out in those patients.

5 MS. BALDWIN: Object to the form.

6 BY MR. EHSAN:

7 Q. Does that make sense?

8 A. Yes. Agree.

9 MS. BALDWIN: And leading.

10 BY MR. EHSAN:

11 Q. So would you agree with me that doctors who
12 have prescribed significant number of prescriptions
13 may have a broader clinical experience with a
14 particular drug based on the number of prescriptions
15 than may allow for a broader set of experiences to
16 share with other prescribers?

17 MS. BALDWIN: Object to the form and
18 leading.

19 THE WITNESS: Yes.

20 BY MR. EHSAN:

21 Q. And lastly, I want to show you what's been
22 marked as Exhibit 3.

23 If you don't mind, John.

24 MR. ZAKRZEWSKI: 3?

25 MR. EHSAN: Yes. Thank you.

1 MR. ZAKRZEWSKI: That one there.

2 MS. CHURCHMAN: What is the --

3 MR. EHSAN: 3 is the email with the funky
4 graphics in the middle.

5 MS. BALDWIN: You produced a lot of
6 documents with those funky graphics.

7 MR. EHSAN: I don't know what that language
8 is, but --

9 MS. BALDWIN: I think that's the secret
10 code.

11 BY MR. EHSAN:

12 Q. Dr. Fishman, you were shown this document
13 yesterday. Do you recall?

14 A. Yes.

15 Q. And I think you mentioned there was an
16 interesting back story to this particular email,
17 which you weren't asked about and during while we
18 were on the record, so I was going to give you that
19 chance to provide that story on the record if you
20 would like.

21 MS. BALDWIN: Object to the form.

22 THE WITNESS: Well, this was a -- you know,
23 again, I'm a little embarrassed because I've tried to
24 hold myself to not being part of advisory boards,
25 only because of the optics of those boards, and I

1 must say that by not being part of those boards, I
2 feel like I've been disadvantaged in learning a lot
3 about medications and the science behind the drugs
4 that we use, but I feel it's important that I --
5 particularly in the roles that I've been in, that I
6 draw those lines.

7 This was an opportunity that came up during
8 the World Congress of Pain that was held in Montreal,
9 and it was a very large international forum where
10 many of the leading pain specialists from Japan were
11 meeting in a conference room, and this company was
12 bringing them together, and I had agreed that I would
13 meet with them. And then later, I was confronted
14 with this need to have me receive -- or to give me an
15 honorarium for participating in an advisory board
16 which this wasn't.

17 This was me meeting with a group of Japanese
18 pain specialists to discuss the problem of opioid
19 abuse in Japan and Asia, and I think in my enthusiasm
20 to take that opportunity to talk with these folks
21 about a problem that I knew of that rarely gets
22 discussed, I overlooked really the problem that was
23 presented in terms of the optics here, but I did
24 refuse to take money, and I offered the option that
25 they could give that money to the university or to a

1 nonprofit.

2 BY MR. EHSAN:

3 Q. So you were basically doing it because you
4 wanted to do it and had no intention of having any
5 remuneration attached to it; correct?

6 MS. BALDWIN: Object to the form and
7 leading.

8 THE WITNESS: That's what I'm saying.

9 BY MR. EHSAN:

10 Q. And you were perfectly fine with the money
11 going to a worthy cause?

12 A. Correct.

13 MS. BALDWIN: Object to the form and
14 leading.

15 BY MR. EHSAN:

16 Q. And then aside from this -- well, this was
17 in -- what year was this?

18 A. This was in 2010.

19 Q. 2010. Have you had any interaction as a
20 speaker or a presenter on behalf of Janssen since
21 2010?

22 A. No.

23 Q. How about with Johnson & Johnson?

24 A. No.

25 Q. How about with Ortho-McNeil?

1 A. No.

2 Q. You recall you were shown a Teva plea
3 agreement that was dated 2016?

4 MS. BALDWIN: Object to the form.

5 THE WITNESS: Plea agreement?

6 BY MR. EHSAN:

7 Q. Yes. Guilty plea agreement.

8 A. I think it was earlier than that if my
9 memory serves me.

10 Q. What was the date? Well, can we just real
11 quick -- sorry. I apologize. I told you that was
12 the last document. Exhibit 31.

13 MS. BALDWIN: It's dated 2008.

14 THE WITNESS: Yeah. Yes, I recall that.

15 BY MR. EHSAN:

16 Q. So aside from this particular email in which
17 you participated in something in Japan, did you have
18 any interaction with Janssen or Johnson & Johnson
19 before -- after 2008?

20 MS. BALDWIN: Object to the form.

21 THE WITNESS: With Johnson & Johnson or
22 Teva?

23 BY MR. EHSAN:

24 Q. With Johnson & Johnson.

25 A. I just want to clarify. The interaction

1 with the Japanese physicians was in Montreal and not
2 in Japan, and I don't actually -- didn't realize that
3 Johnson & Johnson was even involved. There was
4 one -- I did attend a Nucynta advisory board at some
5 point, and I did it because I didn't realize it was
6 an opioid, and, again, this was this dual mechanism.

7 So -- and I think that was 2008, 2009, so
8 that would probably be -- and that was a J&J event
9 that was, I think, in Las Vegas while I was there or
10 something of that sort.

11 Q. So besides this 2008-2009 event relating to
12 Nucynta and the 2010 meeting in Montreal that was
13 discussed in that email, you didn't have interactions
14 with Johnson & Johnson or Janssen since 2007; is that
15 right?

16 A. Correct.

17 MS. BALDWIN: Object to the form.

18 MR. EHSAN: Thank you, doctor.

19 I'll pass the witness.

20 MR. OXLEY: Can we go off the record so we
21 can swap spots?

22 VIDEO OPERATOR: Sure. We're off the
23 record. It's 2:41.

24 (Recess)

25 VIDEO OPERATOR: Okay. We're back on the

1 record. It's 2:44.

2 EXAMINATION

3 BY MR. OXLEY:

4 Q. And, doctor, we met off the record, but my
5 name is Bill Oxley, and I represent Purdue.

6 Doctor, you talked earlier about the
7 lawsuits that had been filed against you by various
8 plaintiffs. Do you recall that?

9 A. Yes.

10 Q. And one of the things that you were shown
11 was a copy of the Settlement Agreement that you
12 entered into; right?

13 A. Correct.

14 Q. Do you remember that in the Settlement
15 Agreement that you entered into, one of the things
16 that happened was that you put together an exhibit
17 that lists -- you or your counsel put together an
18 exhibit that listed all of the lawsuits that you had
19 been sued in? Do you recall that?

20 MR. ZAKRZEWSKI: Objection.

21 You can answer that as it relates to
22 anything you know personally about it absent your
23 communications with your lawyers.

24 THE WITNESS: I don't recall that chart.

25 BY MR. OXLEY:

1 Q. Let me have marked as the next exhibit in
2 order, which is 41 --

3 (Exhibit 41 marked)

4 BY MR. OXLEY:

5 Q. -- a -- this is another copy of a Settlement
6 Agreement that you were talking about earlier today;
7 right?

8 A. Yes.

9 Q. And you'll notice that under the "Recitals,"
10 there's the first, second, third, fourth "Whereas"
11 clause.

12 A. Uh-huh.

13 Q. And, actually, let me go to the first
14 recital, the first whereas clause where it says,
15 Dr. Fishman, that there's "a complete list of all
16 claims currently known by Dr. Fishman as of July 31,
17 2018, attached hereto as Exhibit A." Do you see
18 that?

19 A. I do.

20 Q. And then if you flip --

21 MR. ZAKRZEWSKI: Just for the record, I
22 don't know about your copy, but my copy, it's --

23 THE WITNESS: There are two copies, yeah.

24 MR. ZAKRZEWSKI: It's a double print of the
25 same thing, just so we know what we're dealing with.

1 MR. OXLEY: Thank you. I appreciate it.

2 MR. ZAKRZEWSKI: Okay.

3 BY MR. OXLEY:

4 Q. And then if you go to Exhibit A --

5 A. Yes.

6 Q. -- you'll see that there is an Excel
7 spreadsheet or some sort of spreadsheet that was put
8 together, and it lists all of the lawsuits that were
9 filed in which you were named as a defendant; right?

10 A. Yes.

11 Q. And that starts at Fish 17 and goes all the
12 way through to Fish 24; is that right?

13 A. Yes.

14 Q. And I counted them and came up with about a
15 little bit more than 250 lawsuits that have been
16 filed against you. Does that sound about right?

17 MR. ZAKRZEWSKI: Objection. Form.

18 You can answer to whatever extent you know
19 the number. No communications with counsel.

20 THE WITNESS: I don't know the number. It
21 sounds a little high, but I've been sued in a lot of
22 venues.

23 BY MR. OXLEY:

24 Q. Okay. And all of those lawsuits in which
25 you have been sued were by plaintiffs that alleged

1 that you, along with others, including the
2 organizations that you were involved with, worked
3 with opioid manufacturers to spread false information
4 about the benefits and the risks of opioids; is that
5 right?

6 A. Essentially.

7 Q. And were those allegations against you true?

8 MS. BALDWIN: Objection to form.

9 THE WITNESS: Patently false.

10 BY MR. OXLEY:

11 Q. Okay. Tell the jury why an allegation
12 against you that you were part of a front group that
13 worked with opioid manufacturers to spread lies about
14 opioids is false, please.

15 A. Well, you know, it's hard to prove the
16 negative, but my work has always been to do just the
17 opposite, to highlight the risks, the real risks and
18 the benefits of opioids as a limited option in the
19 treatment of pain, but all I can say is it appears to
20 me that you can sue anyone for anything, and you
21 don't have to actually provide any proof; and in this
22 case, just, you know, you're removed from these
23 cases, and no one ever really cares about the fact
24 that there really were no grounds to support those
25 charges at all and plenty of evidence that would

1 refute them.

2 Q. Is it also false that you worked as a key
3 opinion leader individually with opioid manufacturers
4 in an effort to spread lies about the benefits and
5 risks of opioids?

6 MS. BALDWIN: Object to the form and
7 leading.

8 THE WITNESS: It's --

9 BY MR. OXLEY:

10 Q. The question was whether that was a false
11 allegation against you.

12 MS. BALDWIN: Same objection.

13 THE WITNESS: So that is a false allegation.
14 I never sought to be a key opinion leader. My
15 opinions were respected, and I was sought after for
16 them, and that was, I think, you know, conflated and
17 twisted into some role of being a servant and a shill
18 for the companies that profited on the drugs.

19 BY MR. OXLEY:

20 Q. Conflated and twisted by whom?

21 A. By the plaintiffs who, for some reason,
22 wanted to name me in these -- name me in one case and
23 then have those cases essentially photocopied,
24 Xeroxed word-for-word in hundreds of venues.

25 Q. In this case -- let me just read something

1 to you from some papers that the plaintiffs filed in
2 this case, and I'm going to ask you to let the jury
3 know if this is true or false; okay?

4 MS. BALDWIN: Object to form and leading.

5 BY MR. OXLEY:

6 Q. And I'll represent to you that what I'm
7 reading from you is from an opposition brief that the
8 plaintiffs filed, that the State filed in opposition
9 to a motion to dismiss that Purdue filed in the
10 Oklahoma case, and what it says is that people like
11 you and the organizations that you worked with
12 conspired with Purdue to change the historical form
13 of --

14 MS. BALDWIN: Object to the form. Are you
15 reading the --

16 MR. ZAKRZEWSKI: Wait.

17 MS. BALDWIN: I need a clarification here.
18 Are you reading?

19 MR. OXLEY: Yes.

20 MS. BALDWIN: Are you -- okay. You can
21 reask. I didn't know if you were reading or you were
22 paraphrasing.

23 MR. OXLEY: I said I was reading.

24 MR. ZAKRZEWSKI: But for the court reporter,
25 finish the question, then do your objection.

1 (Discussion off the record)

2 MR. OXLEY: Sure. Let me try it again.

3 BY MR. OXLEY:

4 Q. So in opposition to a brief that Purdue
5 filed, the plaintiff said that you and other KOLs,
6 key opinion leaders, and your front groups, quote,
7 "conspired to change the historical perception of
8 opioids as highly addictive in harmful last resort
9 medications and that that conspiracy supposedly took
10 place with Purdue." Is that true?

11 MS. BALDWIN: Object to the form of the
12 question. I don't believe that you're even reading
13 from the document itself, and if you want to ask him
14 questions about a pleading filed in this case, it's
15 publicly available. Please provide it to the witness
16 and show him what it actually says. You're reading
17 off of your computer. He can't even look at it, and
18 you're representing to the judge and jury that this
19 is what it says, and I don't have it in front of me,
20 I can't look at it. I don't know if that's what it
21 says.

22 So I'm objecting to this whole line of
23 questioning until he has a copy and he can actually
24 read what's written in that document.

25 BY MR. OXLEY:

1 Q. Is that allegation correct, sir?

2 MS. BALDWIN: Object to the form, lacks
3 foundation.

4 THE WITNESS: Can I answer that?

5 MR. ZAKRZEWSKI: (Moves head up and down).

6 THE WITNESS: It's patently false.

7 BY MR. OXLEY:

8 Q. For the same reasons that you described
9 previously, or would you like to add anything to your
10 previous answer?

11 A. I don't even know where to start to argue
12 why that's false. Again, proving the negative is
13 hard, but the fact is that this term "KOL" has
14 become -- they've -- people have framed it as a bad
15 thing to be viewed as someone who has knowledge and
16 respected leader.

17 The fact that some may exploit it doesn't
18 imply that I exploited it. I didn't seek to be a
19 respected -- or a knowledge leader. I sought to do
20 fair and honest work, and there's no evidence that I
21 ever conspired or colluded with drug companies to
22 really do anything, particularly on the level of how
23 they would market their drugs, because I never did
24 any marketing work with these companies.

25 So, again, it appears to me that these are

1 ideas, at least as they relate to me, that are pulled
2 out of thin air that can't be proven, and there
3 really hadn't been any evidence that I've ever seen
4 that would support any of these accusations.

5 Q. If someone were to stand up in court and
6 tell this jury that you, in writing Responsible
7 Opioid Prescribing, were spreading lies that came
8 from the model guidelines and model policy, would
9 that be true?

10 MS. BALDWIN: Object to the form.

11 THE WITNESS: Again, it's not true, and my
12 retort is please read the book.

13 BY MR. OXLEY:

14 Q. If someone were to stand up and tell this
15 jury that the American Academy of Pain Medicine, the
16 American Pain Foundation or any other organization
17 that you were a part of was a front group for opioid
18 manufacturers, would that be true?

19 MS. BALDWIN: Object to the form.

20 THE WITNESS: It would be false and --

21 BY MR. OXLEY:

22 Q. Why?

23 A. Well, I know these organizations, and I know
24 the work they do, and, again, I think that for very
25 selective reasons, being that, I think, lawyers have

1 in these partisan dealings, it's convenient to see
2 that an organization that is doing work and takes
3 money from industry is just simply working for
4 industry, and, unfortunately, it requires someone who
5 understands how consumer and medical education works
6 across the board.

7 Has nothing to do specifically with opioids
8 or pain, how it works in America where professional
9 groups and consumer groups are forced to get funding
10 to do the good work they do from industry because
11 industry is the only source that actually is making
12 money from the therapeutic endeavors that we're
13 trying to educate on.

14 So I think this is a very selective attempt
15 to sway opinions of people who don't have enough
16 knowledge to really understand that these are groups
17 that are trying to do great good, they're very
18 dedicated people, and, unfortunately, they can't do
19 their work without funding.

20 Q. And in your view, is it a good thing, a bad
21 thing or something else for industry to support the
22 goals of those organizations that you just described
23 who are out there trying to do good work?

24 MS. BALDWIN: Object to the form and
25 leading.

1 THE WITNESS: I think it's an unfortunate
2 reality that we have to have this uncomfortable
3 alliance. My hope is that it changes across the
4 board, but to date, otherwise, there's really -- you
5 know, most of the continuing medical education in
6 America is funded through industry, and if you stop
7 those relationships today, we'd stop that education.

8 So we've got to figure out something in
9 America that allows us to do it better, but it's the
10 best we have, and it's the system that we have, and
11 those of us who want to make sure that clinicians and
12 consumers are educated have to work with industry.

13 BY MR. OXLEY:

14 Q. And I think you said before that you never
15 allowed funding, regardless of where it came from, to
16 influence any of your work; is that right?

17 MS. BALDWIN: Object to the form and
18 leading.

19 MR. OXLEY: It's foundational.

20 BY MR. OXLEY:

21 Q. Is that right?

22 A. I work very hard to keep my work
23 independent.

24 Q. One of the things, I think, that you said
25 that you try to avoid was an apparent conflict of

1 interest. You said that yesterday, and you may have
2 said it today. Do you remember that?

3 A. I do.

4 MS. BALDWIN: Object to the form.

5 BY MR. OXLEY:

6 Q. When you said you were trying to avoid an
7 apparent conflict of interest, can you please tell
8 the jury what you meant by an "apparent conflict"?

9 A. Well, highlight the "apparent conflict of
10 interest" because I know it's not a conflict of
11 interest. I know that I'm not being influenced, but
12 others don't know that.

13 So in leadership roles, as I ascended to
14 leadership roles in the field, I felt less
15 comfortable having apparent conflicts of interest and
16 have ultimately excluded as many of them as I can,
17 even when it's detrimental to my own learning or
18 advantages to the work that I do.

19 Q. And one of the ways that you experienced
20 that problem for you of having an apparent conflict
21 of interest was when ProPublica published an article
22 about you; correct?

23 A. Correct.

24 MS. BALDWIN: Object to the form.

25 BY MR. OXLEY:

1 Q. And can you tell the jury what happened in
2 that scenario with the ProPublica article?

3 MS. BALDWIN: Object to the form.

4 THE WITNESS: They just published an article
5 that, you know, essentially cast me as a -- you know,
6 as someone in the pocket of or a shill for
7 pharmaceutical companies because -- by association
8 with organizations that accepted funding from
9 industry and other roles that I had, like inaccurate
10 information about the video that I did for the public
11 service announcement on opioid addiction in
12 adolescents that happened to go on a marketing
13 website, unbeknownst to me, that I wasn't paid for,
14 but it was represented that I did, etc. So I
15 thought -- you know, it was character assassination
16 by association.

17 BY MR. OXLEY:

18 Q. Let me have marked as the next document in
19 order an article that we printed out that's called
20 "Dollars for Doctors, Two Leaders in Pain Treatment
21 Have Long Ties to Drug Industry," and it's a
22 ProPublica article.

23 (Exhibit 42 marked)

24 BY MR. OXLEY:

25 Q. And my question, doctor, is if Exhibit 42 is

1 the article that you were just talking with the jury
2 about.

3 A. Yes.

4 Q. Let me have marked as the next document in
5 order an email chain that appears in -- or let me try
6 that again. An email chain on or around December 26,
7 2011. It bears production numbers Fish 6389 through
8 Fish 6391.

9 (Exhibit 43 marked)

10 BY MR. OXLEY:

11 Q. And my question, doctor, is if Exhibit 43 is
12 an email exchange that you were a part of, including
13 parts that you wrote, on or around December 26, 2001.

14 A. I'm sorry. Can you restate that?

15 Q. Sure.

16 MR. ZAKRZEWSKI: The date.

17 BY MR. OXLEY:

18 Q. Did I mess up the date? Is Exhibit 43 a
19 copy of an email exchange that you were a part of
20 dated on or around December 26, 2011?

21 A. Yes.

22 Q. And at the time that you prepared this
23 email, were you attempting to be accurate in the
24 events that you described in the email?

25 A. I believe so. I was pretty upset.

1 Q. And do you believe that you did accurately
2 describe the events and the way that you were feeling
3 about them in or around December 26, 2011?

4 A. If you want to give me a chance to read
5 this, I'll try to read it.

6 Q. Sure.

7 A. I haven't read it in a long time, probably
8 eight years.

9 Q. Sure. And I don't have very many questions
10 about it. I'm just trying to establish a foundation
11 that this is actually a document that you prepared at
12 or around this time.

13 A. This is an email that I sent to the board of
14 directors for the American Pain Foundation, so these
15 were my thoughts.

16 Q. Okay. Thank you. One of the things that
17 you said in the third sentence of your email, which
18 appears in the top quarter of the page, is "In my
19 specific case, I believe the reporters intended to
20 defame my reputation by publishing false, incomplete
21 and conflated facts." Is that correct? Did I read
22 that correctly?

23 A. Yes.

24 Q. And that's an accurate statement of what you
25 believed at the time?

1 A. And what I still believe.

2 Q. In the second full paragraph, you say -- in
3 about the -- toward the end of the second full
4 paragraph, you say, quote, "It is unsophisticated,
5 simplistic and misleading for ProPublic to present a
6 unidimensional picture that portrays APF as a pawn in
7 the opioid industry."

8 Did I read that correctly?

9 A. Yes.

10 Q. And is that what you believed then and what
11 you believe now?

12 A. Yes.

13 Q. You go on to say that "Such a story belies
14 the basic facts that, one, opioids are an essential
15 drug group in medicine that can be safe and effective
16 when prescribed by well-educated and trained
17 physicians; that chronic pain patients have a
18 legitimate right to organize and advocate for access
19 to pain relief, including opioids; and that there is
20 a paucity of nonindustry funding sources for patient
21 education and prescriber education," close quote.

22 Did I read that correctly?

23 A. You did.

24 Q. Do you believe those statements that you
25 made -- or did you believe those statements that you

1 made when you wrote them, and do you believe them
2 now?

3 A. I do.

4 Q. In the next paragraph, you say, quote,
5 "Everyone acknowledges that America is facing a
6 time-sensitive need for education in safe and
7 effective opioid prescribing, including the APF, DEA
8 and FDA. It is therefore specious reasoning to fault
9 industry funding for education in this area if there
10 are not alternative funders prepared to take on this
11 role. Even Congress and the FDA are requiring
12 industry to pay for physician education, and they
13 have made consumer education a high priority," close
14 quote.

15 Did I read that correctly?

16 A. You did.

17 Q. Did you believe that when you wrote it, and
18 do you believe it today?

19 A. Yes, on both fronts.

20 Q. APF was the American Pain Foundation? Is
21 that who you're referring to?

22 A. Yes.

23 Q. DEA is?

24 A. The Drug Enforcement Agency.

25 Q. And the FDA?

1 A. The Food and Drug Administration.

2 Q. And in the previous paragraph, you refer to
3 a "paucity," I can't say it right, "of nonindustry
4 funding." What did you mean when you said "paucity"?

5 A. "Paucity" is a lack of.

6 Q. So there was a lack of funding?

7 A. Yes.

8 MS. BALDWIN: Object to the form.

9 BY MR. OXLEY:

10 Q. One of the things that you said in your
11 email and that you criticize ProPublica for was its
12 failure to publish more of the details in your
13 responses to specific written questions that
14 ProPublica had asked you; is that right?

15 MS. BALDWIN: Object to the form.

16 THE WITNESS: Correct.

17 BY MR. OXLEY:

18 Q. Let me hand you, which we'll have marked as
19 Exhibit 44, a document that appears to be your
20 response to the reporters from ProPublica. I'll note
21 for the record that for some reason, this was printed
22 with stuff that I had highlighted in it, and at the
23 time of trial, we'll be more than happy to replace
24 clean versions of this for the ones that have this
25 highlighting.

1 (Exhibit 44 marked)

2 BY MR. OXLEY:

3 Q. My question -- my first question,
4 Dr. Fishman, is if the document that we've had marked
5 as Exhibit 44 is in fact a copy of your response to
6 the questions that were proposed by ProPublica
7 authors Charles Ornstein -- well, Charles Ornstein
8 dated December 15th, 2011.

9 A. These are my responses to written questions
10 that were posed to me prior to publishing their
11 article.

12 Q. And when you prepared your written responses
13 to the questions that were posed before ProPublica
14 wrote its article, did you make sure that your
15 written responses were accurate and reflected what
16 you believed at the time you wrote those answers?

17 MS. BALDWIN: Object to the form.

18 THE WITNESS: Yes.

19 BY MR. OXLEY:

20 Q. In the response on the first page to
21 question number one, you say "Your characterization
22 of my presentations and articles on opioids as being
23 upbeat is incorrect. I would not say that I am
24 upbeat at all about the current environment in which
25 too many people are using opioids inappropriately."

1 Did you believe that at the time, and do you
2 believe it today?

3 A. Yes.

4 MS. BALDWIN: Object to the form.

5 BY MR. OXLEY:

6 Q. On the next page, the first full paragraph,
7 you say "Opioids are addictive, but I doubt that most
8 medical leaders would agree that they are only to be
9 used as a last resort." Did you believe that at the
10 time you wrote it?

11 A. Yes.

12 Q. Do you believe it today?

13 A. Yes.

14 Q. The last two sentences of that same
15 paragraph says "Medicine is all about risk
16 management. Physicians always have to balance risks
17 with benefits. Unfortunately, until recently, this
18 was never emphasized around the use of opioids or
19 controlled substances in general."

20 Did you believe those statements when you
21 wrote them, and do you believe them today?

22 A. Yes.

23 Q. One of the things that you wrote on page
24 four, carrying over to page five, is you're talking
25 about the number of people in America that suffer

1 from chronic pain, and you can see that at the top of
2 page four where you say that "we need to treat the
3 116 million Americans (per the recent Institute of
4 Medicine report) in chronic pain and the many more
5 millions in other forms of pain every day."

6 Do you see that?

7 MR. ZAKRZEWSKI: Where are you?

8 BY MR. OXLEY:

9 Q. It's at the top of page four.

10 MR. ZAKRZEWSKI: You said four.

11 BY MR. OXLEY:

12 Q. Yeah. The sentence started on four but
13 carried over to five. Sorry.

14 MR. ZAKRZEWSKI: Okay.

15 THE WITNESS: Yeah.

16 BY MR. OXLEY:

17 Q. Is that a statement that you believed at the
18 time when you wrote it?

19 A. I think so. I think I've given more thought
20 to the -- number one, since I wrote it, the 116 has
21 been revised to 100 million by the Institute of
22 Medicine, or now the National Academy of Medicine,
23 and, again, understanding that population, it's
24 probably not all that 100 million need to be treated
25 but need to be considered, so that would hold to

1 that.

2 Q. But when you wrote it back in 2011 --

3 A. Yes.

4 Q. -- there's no doubt that you believed it;
5 right?

6 A. Correct.

7 Q. And the fact that your thinking about that
8 has changed, is that part of what you were talking
9 about earlier when you talked about how science
10 evolves and people's views of what the science is
11 telling us evolves with it?

12 MS. BALDWIN: Object to the form and
13 leading.

14 THE WITNESS: Yes.

15 BY MR. OXLEY:

16 Q. One of the documents that you talked about
17 yesterday -- or one of the manuscripts that you
18 talked about yesterday was a book by Derek McGinnis
19 called "Exit Wounds," and I have a copy of it here
20 that I would like to have marked as Exhibit 45.

21 (Exhibit 45 marked)

22 BY MR. OXLEY:

23 Q. And, doctor, you prepared the forward to the
24 book Exit Wounds; is that right?

25 A. Yes.

1 Q. And when you prepared the forward to Exit
2 Wounds, you were attempting to write something that
3 you believe; is that true?

4 A. Yes, absolutely.

5 MS. BALDWIN: Object to form.

6 BY MR. OXLEY:

7 Q. Am I correct that Exit Wounds was developed
8 by the American Pain Foundation?

9 A. Yes.

10 Q. And you were the president of the American
11 Pain Foundation; correct?

12 A. I was the chairman of the board, but yes. I
13 had the title president, but it had no -- it didn't
14 have any role.

15 Q. Okay.

16 A. Yeah.

17 Q. And you were the president and chairman of
18 the American Pain Foundation at the time Exit Wounds
19 was published?

20 A. Correct.

21 Q. So can you tell the jury, based on your
22 involvement in writing this and your work for the
23 American Pain Foundation at the time Exit Wounds was
24 funded, if Exit Wounds was an attempt to spread lies
25 about the use of opioids?

1 MS. BALDWIN: Object to the form.

2 THE WITNESS: Exit Wounds was a book I wrote
3 a preface or forward for. I wasn't involved in
4 writing the book, but the American Pain Foundation
5 had become connected with Derek McGinnis, who was a
6 war veteran who had a traumatic limb amputation due
7 to stepping on a mine and went through a horrendous
8 experience of overcoming acute and chronic pain; and
9 the foundation felt that it was a very compelling
10 story to tell and used its resources to put together
11 this book that tells Derek McGinnis's story of his
12 path of being a normal adult to a traumatized -- both
13 physically and mentally traumatized veteran.

14 There was, in my estimation, no connection
15 to drugs or pharmaceutical companies in this book.
16 The fact that they sought pharmaceutical money to
17 print the book and get the book out reflects the need
18 for money, reflects the need for support to be able
19 to get projects like this completed.

20 And I can understand why some people might
21 say, "Well, if they're taking money from
22 pharmaceutical companies, they must be doing
23 pharmaceutical companies' work," but there were
24 firewalls involved in this work, and, again, as the
25 American Pain Foundation did its work, we put our

1 projects out onto anyone who wanted to fund it, and I
2 think Purdue and others chose to fund this project.

3 BY MR. OXLEY:

4 Q. When you said that they were seeking
5 funding, you mean the American Pain Foundation was
6 seeking funding?

7 A. American Pain Foundation was seeking
8 funding, correct, for a project that the American
9 Pain Foundation chose to do. I wasn't on the ground
10 doing projects with the group. Again, my role was
11 with the board of directors, you know, at a very high
12 level.

13 Q. You said that you understood why someone
14 might see that there's funding from a pharmaceutical
15 company and then make the assumption that there was
16 influence.

17 A. Correct.

18 Q. In the case of Exit Wounds, is that
19 assumption true or false?

20 A. The assumption is false, and I think if you
21 met Derek McGinnis, you would understand that
22 viscerally.

23 Q. Why is that?

24 A. Because he's such a compelling example of
25 what we have to learn about how pain takes over your

1 life, and this story is about that. Again, you know,
2 my retort is always read the book. Before you make a
3 judgment, read the book. The book's not about drugs.
4 The book's about a story of coming back to life from
5 this enormously traumatic experience that many people
6 would have folded from.

7 Q. And if opioids are able to help someone come
8 back to life, as you put it, is that something that
9 you would support for that particular patient under
10 those particular circumstances?

11 MS. BALDWIN: Object to the form.

12 MR. ZAKRZEWSKI: Objection. Form.

13 You can answer.

14 THE WITNESS: I honestly don't know the
15 circumstances under which Derek received his
16 treatment, and I couldn't say in that case.

17 BY MR. OXLEY:

18 Q. I didn't mean Derek in particular.

19 A. But in a case of someone in which all things
20 that would have potential to help with less risk have
21 been tried, it's urgent that you help somebody
22 recover from injuries like this, and I think if Derek
23 didn't get the help that he needed in time, his life
24 would have been forever injured further than it was.

25 Q. One of the things that you said in the

1 forward that you prepared is that, quote, "Chronic
2 pain, whether suffered by individuals in the civilian
3 or military community, is a special kind of hell,"
4 close quote. Is that something that you believed
5 then and that you believe now?

6 MS. BALDWIN: Object to the form.

7 THE WITNESS: Both, yes.

8 BY MR. OXLEY:

9 Q. We've talked a lot about chronic pain, and
10 I'd like to give you a chance to tell the jury what
11 that means. What have you observed in patients who
12 are in chronic pain, and how does chronic pain -- why
13 is it a special kind of hell as you described in the
14 preface?

15 MS. BALDWIN: Object to the form.

16 THE WITNESS: Well, chronic pain is a
17 special kind of hell because it's the aberrant
18 activation of an adaptive alarm system that's meant
19 to keep us safe which, when broken, makes our lives
20 miserable by virtue of the fact that it's an alarm --
21 the pain alarm is meant to grab our attention, and
22 when it grabs our attention, it's due to potential
23 harm, real harm and the process of healing.

24 The alarm is designed to turn off once we
25 start that healing process or the threat is gone.

1 When that alarm will be turned off, it constantly
2 signals us that we need to focus on only the alarm
3 and remove our focus from all the other things that
4 make life worth living, and you can see this in how
5 it would be adaptive in history, that you've injured
6 yourself, and you need to stop collecting food in the
7 field, or whatever you're doing, and pay attention,
8 and your behavior attracts others to understand
9 what's happening to you, and you can get support to
10 survive and advance the species.

11 When that alarm is constantly ringing, it's
12 telling you to stop. It's like having mental
13 handcuffs all the time. And there are ways that many
14 people can deal with that, which involve drugs,
15 non-drugs, many different adaptations that can be
16 helpful, but overall, if you can imagine having to
17 wear a full body cast or handcuffs on your feet and
18 your hands and go through life, that would seem like
19 hell, and that's what these patients go through
20 because it's unrelenting, and they don't have the
21 opportunities the rest of us have to have
22 full-quality lives.

23 BY MR. OXLEY:

24 Q. On the next page, you write, quote, "The
25 goal of Exit Wounds is to arm veterans and their

1 families with the information and resources they need
2 to advocate for the quality of pain treatment they
3 deserve," close quote. Is that a true statement?

4 MS. BALDWIN: Object to the form.

5 THE WITNESS: Yes.

6 BY MR. OXLEY:

7 Q. You meant it when you wrote it?

8 A. And mean it today.

9 Q. One of the things that -- let me ask you
10 this: In looking at your writing, one of the things
11 that -- and my question is whether what I'm about to
12 say is right or wrong: One of my take-aways was that
13 not only are you passionate about helping people with
14 pain, but that you are looking for ways to talk with
15 patients about pain in a way so that they can get the
16 best help possible. Is that a true or false
17 statement?

18 MS. BALDWIN: Object to the form and leading
19 and testifying.

20 THE WITNESS: Yes.

21 BY MR. OXLEY:

22 Q. True?

23 A. True.

24 Q. And what, in your -- do you ever use any
25 visual aids in your practice to help patients

1 describe their levels of pain?

2 A. I don't.

3 Q. Have you ever -- but you have written an
4 article before, we were looking at it earlier,
5 Exhibit 38, in which you had a picture of a visual
6 aid; right?

7 MS. BALDWIN: Object to the form.

8 THE WITNESS: The scale with faces.

9 BY MR. OXLEY:

10 Q. Yes. And let's take a look, if we could,
11 which is page --

12 MR. ZAKRZEWSKI: Got to get it for you.

13 BY MR. OXLEY:

14 Q. -- eight. Thank you. And I'm looking at
15 the page numbers at the top where it says page --
16 it's at the top right-hand side. Right. And,
17 actually, could you hold that up to the camera so the
18 jury can take a look? These are -- what the jury's
19 looking at right now is something from Wong-Baker; is
20 that right?

21 A. Correct.

22 Q. And what the jury's looking at right now is
23 the depiction of the faces from Wong-Baker that you
24 put in the article that you wrote that is Exhibit 38;
25 right?

1 A. Correct.

2 Q. And one of the things that -- am I right
3 that in your article, you were using that as an
4 example of a way to get people to talk about their
5 levels of pain?

6 MS. BALDWIN: Object to the form.

7 THE WITNESS: Well, it's one of the tools
8 that's commonly used, and some people like to use
9 that. I don't use it in my practice, but this is the
10 work I do every day with almost every patient. So I
11 feel particularly comfortable talking with patients
12 about their pain, and I feel that I get a better
13 sense from having a more detailed conversation that
14 may take longer.

15 Some doctors or clinicians might not have
16 the time that I have. So this is a very quick way to
17 get a patient to kind of give you a sense of where
18 you are, where they are. It also may be
19 oversimplifying where they are and how they're
20 feeling.

21 BY MR. OXLEY:

22 Q. And one of the things that you said in your
23 article is, quote, "The Wong-Baker scale in Figure 1
24 is suitable for patients of all ages except the very
25 young, those of all cultures and those who are

1 cognitively impaired." And do you believe that
2 today, and did you believe it then?

3 MS. BALDWIN: Object to the form.

4 THE WITNESS: I believe it as far as there's
5 data that suggests that that's true.

6 BY MR. OXLEY:

7 Q. Great. Thank you. What would you think of
8 a lawyer who would stand up in court and make fun of
9 the Wong-Baker faces chart as being an example of
10 some pharmaceutical company that's making light of
11 opioids and people who are in pain?

12 MS. BALDWIN: Object to the form.

13 MR. ZAKRZEWSKI: Objection. Form.

14 MS. BALDWIN: That has never happened.

15 THE WITNESS: Should I answer that?

16 MR. ZAKRZEWSKI: Answer it if you know.

17 THE WITNESS: Well, I think it would be an
18 example of someone who doesn't understand the
19 complexity of pain and particularly doesn't
20 understand how difficult it is to put markers on the
21 pain that someone's feeling.

22 I think people are very surprised to learn
23 that we don't have a pain meter, we can't measure how
24 much someone has pain, so it's an easy target to say
25 that our imperfect means of trying to put some

1 measure on pain is so inadequate that maybe it's just
2 being done as a ruse to support the, you know, profit
3 mongers who we're conspiring with, but, frankly, I
4 think they're missing what is actually happening
5 which is that pain is a subjective experience.

6 You can't prove whether anyone does or
7 doesn't have it, and you can't prove that anyone does
8 or doesn't have pain relief. So these are ways in
9 which we're trying to get partial information that we
10 know is subjective from individuals in some unified
11 way, in some way that is reproducible so that we can
12 try to have pathways that help guide us in our
13 decision making.

14 BY MR. OXLEY:

15 Q. Based on your research and understanding of
16 the data, is the use of the Wong-Baker faces chart
17 something that's designed to help get a conversation
18 started about a patient's level of pain?

19 MS. BALDWIN: Object to the form.

20 THE WITNESS: Right. It's designed to
21 appeal to someone who would recognize the emotional
22 attributes of the different faces and maybe be able
23 to put themselves on that spectrum. Not every
24 patient wants to do that, and you've got to shift to
25 the patient as we said. It's always got to be

1 individualized, but sometimes that's the one that
2 works best with the patient.

3 Again, I always do it with words, but it's a
4 more involved intervention than just showing them a
5 zero to ten scale where ten's the worst pain and
6 zero's none or the Wong-Baker faces, and there are
7 other tools out there as well. They're all, frankly,
8 inadequate.

9 BY MR. OXLEY:

10 Q. Thank you. And I'm sorry to keep turning.

11 A. No, no problem.

12 Q. I'm not trying to be rude.

13 A. No, no problem.

14 Q. I'm just trying -- somebody's telling me I'm
15 running out of time soon.

16 Doctor, let me have marked as the next
17 exhibit in order which --

18 (Exhibit 46 marked)

19 BY MR. OXLEY:

20 Q. And Exhibit 46 is entitled "Chapter 1, The
21 Clinician's Dilemma: Undertreated Pain Versus
22 Prescription Drug Misuse," and it bears production
23 numbers Fish 609 through 619, and the copyright date
24 is 2012, and my question, doctor, is if the document
25 that has been marked as Exhibit 46, which I'll call

1 Chapter 1, is a chapter that was written by you.

2 A. It is.

3 Q. At the time that you wrote Chapter 1, did
4 you believe that the statements that you were making
5 in Chapter 1 were supported by the science that was
6 available to you at the time?

7 A. I think that the statements that I make in
8 Chapter 1 are proportionate to the science that was
9 available at the time. There wasn't science to
10 support all of the things -- science is inadequate,
11 unfortunately, so I think, you know, what we do is we
12 do the best with the inadequate science that we have,
13 and that's the case with this chapter.

14 Q. And with respect to this chapter -- and I
15 appreciate what you said. With respect to this
16 chapter, the statements that are made in Chapter 1,
17 were they statements that you believed at the time
18 you wrote them?

19 A. Yes. I was hoping we could read most of
20 this.

21 Q. I sense that there's a little bit of
22 sarcasm.

23 A. No. No. I'm all for what this says.

24 MR. ZAKRZEWSKI: I think quite the contrary.

25 THE WITNESS: Yeah.

1 BY MR. OXLEY:

2 Q. Was there any particular part of it that you
3 would like the jury to know about?

4 A. Well, I would ask the jury to read it if
5 they feel that they have a question about where my
6 perspective is. It's all about safety.

7 Q. Okay. And what we'll do is if we have time,
8 we can come back to it when I'm done with this other
9 stuff if that's all right.

10 A. Yes.

11 Q. Thank you. One of the things that you
12 talked about previously involved questions about the
13 prescription of opioids for a long term. Do you
14 recall that?

15 MS. BALDWIN: Object to form.

16 THE WITNESS: Can you say that again?

17 BY MR. OXLEY:

18 Q. I'm going to try to say it better.

19 A. Yeah.

20 Q. Okay. One of the things that you were asked
21 questions about earlier was whether today, you would
22 prescribe opioids for long-term use.

23 A. Uh-huh.

24 Q. Do you recall that?

25 A. I do.

1 Q. When you use the phrase "long-term use"
2 today, what do you mean by that?

3 A. I consider long-term use of opioids that are
4 prescribed without an end date.

5 Q. Thank you. If you were asked to make a
6 determination about whether a patient had been
7 prescribed an opioid that was medically unnecessary,
8 would you be able to -- what information would you
9 need to be able to make that determination?

10 MS. BALDWIN: Object to form.

11 BY MR. OXLEY:

12 Q. And to put it the flip side, to determine if
13 something was medically necessary, what would you
14 need? What information would you want?

15 MR. ZAKRZEWSKI: Object to form.

16 THE WITNESS: So you're asking what
17 information would I use if I was to make a
18 determination that a medical decision to prescribe an
19 opioid was inappropriate or appropriate?

20 BY MR. OXLEY:

21 Q. That's so much better. Thank you, doctor.

22 A. Just wanted to be sure. Again, there's very
23 clear guidance on this that clinicians need to get a
24 full history, do a particularly focused history, to
25 do a appropriate physical examination, to consider

1 the past history, to do screening that is consistent
2 with potentially stratifying risk and to consider all
3 of the other parts of the complaint and the patient's
4 presentation, their psychosocial behavioral history
5 in making a determination whether the benefits
6 outweigh the risks.

7 Q. When you said that there was clear guidance,
8 where is that clear guidance?

9 A. I think the two most prominent guiding
10 documents or provisions for clinicians are the CDC
11 guidelines on opioid prescribing and the FSMB model
12 policy.

13 MS. BALDWIN: I'm going to object to this
14 whole line of questioning as attempting to elicit
15 expert testimony from an individual who is not
16 disclosed by defendants as an expert in this case.

17 MR. OXLEY: Noted. Thank you.

18 BY MR. OXLEY:

19 Q. Would you feel comfortable -- let me strike
20 that.

21 Would it be proper, in your view, based on
22 what you've done for the last many years, to make a
23 determination about whether or not an opioid
24 prescription was proper or improper if you never saw
25 the patient and never looked at the medical records

1 for the patient?

2 MS. BALDWIN: Object to the form. Same
3 objection.

4 THE WITNESS: I mean it would be difficult,
5 you know, if, you know, you came to me and said,
6 "Here's a doctor who prescribed opioids for a patient
7 and was paid cash and they had sex, you know, at the
8 time," I would say, you know, I don't need to see the
9 record if those are the facts, you know. They're
10 egregious lines that are clearly unprofessional
11 behaviors, but, you know, if it's more nuanced than
12 that, I'd probably have to see records and
13 potentially see the patient.

14 BY MR. OXLEY:

15 Q. One of the things that you talk about in
16 some of your writing is the concept of
17 pseudoaddiction. Are you familiar with that term?

18 A. I am.

19 Q. And what does that mean?

20 A. Pseudoaddiction means that the patient has
21 signs or the appearance of addiction but in fact is
22 not.

23 Q. And that's something that you wrote about in
24 Responsible Opioid Prescribing; right?

25 A. Yes.

1 Q. Based on your knowledge and based on your
2 research, is pseudoaddiction something that was made
3 up by pharmaceutical companies in order to sell
4 opioids?

5 MS. BALDWIN: Object to form.

6 MR. ZAKRZEWSKI: Object to form.

7 You can answer.

8 MS. BALDWIN: Leading.

9 THE WITNESS: In my opinion, it was not made
10 up by pharmaceutical companies. It's a real entity.
11 I don't know how common it is, but, unfortunately,
12 it's a concept that's been misunderstood and misused
13 to justify giving people more opioids than they
14 should get and not having vigilance around whether
15 they are or are not potentially abusing drugs, of
16 which addiction is only a small part.

17 BY MR. OXLEY:

18 Q. And so because of the objection, let me ask
19 a slightly different question.

20 Is pseudoaddiction a real thing?

21 A. Oh, yes.

22 MS. BALDWIN: Object to form.

23 THE WITNESS: There are patients who appear
24 to be addicted who aren't.

25 BY MR. OXLEY:

1 Q. Thank you. Yet another copy of Responsible
2 Opioid Prescribing which I'll have -- whoops -- I'm
3 sorry. Which I'll have marked as -- I think we're on
4 47.

5 (Exhibit 47 marked)

6 BY MR. OXLEY:

7 Q. And I will represent to you, doctor, that
8 one of the associates in my office purchased this on
9 Amazon as a used book, and this is a copy of what was
10 purchased.

11 A. This is an early edition.

12 Q. An actual book that was published, though,
13 and sold; right?

14 A. Yes.

15 Q. Because where we are on time -- you know
16 what? I'll just leave it at that. Let's move on to
17 the next one for now.

18 You were asked some questions yesterday
19 about comments that you received from Dr. Haddox. Do
20 you recall that?

21 A. I do.

22 Q. And comments on Responsible Opioid
23 Prescribing; right?

24 A. Correct.

25 Q. Okay. And I think you went into that in a

1 fair amount of detail yesterday, so I won't go over
2 much of it again today, but I just wanted to ask you
3 the question if in any way you felt pressured or
4 required to make any of the changes that Dr. Haddox
5 suggested.

6 MS. BALDWIN: Object to form.

7 THE WITNESS: I only felt pressured to make
8 the grammar changes that he, unfortunately, found. I
9 don't recall there being any real substantive content
10 changes, but at no point did I feel obligated to make
11 any changes that he would have suggested.

12 BY MR. OXLEY:

13 Q. The Settlement Agreement that we talked
14 about earlier refers to a Proffer Agreement. Is that
15 a written agreement?

16 A. I believe it is.

17 Q. And did you get a copy of that?

18 A. I probably did.

19 Q. You talked about the proffer session that
20 you had with the plaintiffs' lawyers --

21 A. Uh-huh.

22 Q. -- as part of your settlement; right?

23 A. Yes.

24 MS. BALDWIN: Object to form.

25 BY MR. OXLEY:

1 Q. How many plaintiffs' lawyers were in the
2 room when you had that meeting?

3 MS. BALDWIN: Object to form.

4 THE WITNESS: I believe it was six.

5 BY MR. OXLEY:

6 Q. Were there any people on the phone or
7 appearing by videoconference?

8 A. Not that I recall.

9 Q. Was your proffer meeting -- as far as you
10 know, was it videotaped or audio recorded or anything
11 like that?

12 A. It was not.

13 Q. Did you prepare -- have you prepared any
14 affidavits or declarations or any other statements
15 under oath for any plaintiffs' lawyer?

16 A. No.

17 Q. Doctor, I have a couple questions about
18 exhibits. I'm going to try to do it all at once
19 because of where we are.

20 A. Okay.

21 Q. So I'm going to ask your lawyer to put in
22 front of you exhibits, which were internal Purdue
23 documents that you were shown yesterday, and they are
24 Exhibits 8, 9, 18, 23, 24, 25 and 31.

25 MR. ZAKRZEWSKI: It would be helpful --

1 anybody have a paper clip? Hand me that little
2 binder clip. This one kind of came apart, so I'm
3 putting it together. I got 25, I got 24, 23, got 31
4 first.

5 BY MR. OXLEY:

6 Q. And my general question, Dr. Fishman, about
7 those documents is whether you played any role at all
8 in the preparation of any of those Purdue documents.

9 A. I don't believe I did.

10 Q. Do you have any personal knowledge about
11 whether any of the events that you were asked about
12 when you were looking at those documents --

13 MR. ZAKRZEWSKI: Can I pause?

14 MR. OXLEY: Sure.

15 MR. ZAKRZEWSKI: He just responded, "I don't
16 believe I did."

17 I want you to look at those documents before
18 you give the actual answer to the question.

19 MR. OXLEY: Do you mind if we go off the
20 record while he takes a look?

21 MR. ZAKRZEWSKI: That's fine.

22 MR. OXLEY: Thank you.

23 MR. ZAKRZEWSKI: I want a clear answer on
24 this.

25 VIDEO OPERATOR: Sure. We're off the

1 record. It's 3:42.

2 (Recess)

3 VIDEO OPERATOR: Okay. We're back on the
4 record. It's 3:43.

5 BY MR. OXLEY:

6 Q. Dr. Fishman, while we were off the record,
7 did you have an opportunity to review the documents
8 that your counsel put in front of you?

9 A. Yes.

10 Q. And my question is whether you had any
11 involvement in the preparation of any of the internal
12 Purdue documents that you were shown yesterday and
13 asked questions about.

14 A. No, I did not.

15 Q. Thank you. From your own personal
16 knowledge, do you have any information about whether
17 anything that was discussed in any of those
18 documents, the internal Purdue documents, actually
19 took place?

20 MS. BALDWIN: Object to the form.

21 THE WITNESS: I don't. I'm assuming that
22 they're real documents and they took place, but I
23 have no specific knowledge of really their context or
24 how they were used or how they came to exist.

25 BY MR. OXLEY:

1 Q. And what I'm asking you -- I'm not asking
2 you about whether they're actual documents or not
3 actual documents. You were asked some questions
4 yesterday about if it makes sense, in reading the
5 document, if this happened --

6 A. Uh-huh.

7 Q. -- or would it surprise you if this happened
8 or if this happened, is it something that you would
9 have wanted to know about, and what my question is is
10 whether you know if any of those things that were the
11 "if this happened" in those questions actually
12 happened.

13 MS. BALDWIN: Object to form.

14 THE WITNESS: I don't believe I know that
15 any of those things happened.

16 BY MR. OXLEY:

17 Q. Thank you. One of the documents that you
18 were shown yesterday -- well, never mind. I won't
19 ask about that one.

20 You said that -- when did you first start --
21 when did you first prescribe an opioid for a patient?

22 A. When I was an internal medicine resident
23 early after graduating medical school.

24 Q. And you said that that's something that you
25 still do today; right?

1 A. Correct.

2 Q. And you also said at some point today that
3 the benefits of opioid medications are not well
4 established. Do you recall saying something like
5 that?

6 A. The benefits of chronic opioids for chronic
7 pain is weak and inadequate to really understand who
8 we should give them to and to justify the benefits on
9 their face.

10 Q. And today, do you still, from time to time,
11 prescribe opioids for patients with chronic pain?

12 A. I do.

13 Q. Why?

14 A. Because the risk benefit analysis supports
15 taking that risk, and it's as simple as that. It's
16 hard to get to that point, and it's not common. It's
17 less and less common because the data is mounting,
18 that there's greater risk than we knew and that when
19 an opioid fails at low dose, that going to high dose
20 actually increases the risk.

21 This is information we didn't have when I
22 was an internal medicine resident, so the outcome of
23 that decision process changes, has changed as our
24 understanding has evolved.

25 Q. But today, if the risk benefit analysis

1 weighs in favor, in your medical judgment, of
2 prescribing an opioid to a patient with chronic pain,
3 what would you do?

4 A. I would share that determination with the
5 patient, and we'd make a shared decision about
6 whether they want to try an opioid, and I would have
7 to educate them on what we're doing and where we're
8 going with it and what the opportunity is, and they
9 would have to make an informed decision to try it,
10 but I would be willing to partner with them, with
11 prescribing that opioid.

12 Q. And if they made that informed decision that
13 that is something that they would like to try, would
14 you then write a prescription for the opioid assuming
15 again that, in your medical judgment, it would be
16 beneficial to a patient with chronic pain?

17 MS. BALDWIN: Object to form.

18 THE WITNESS: And assuming that we did all
19 the things that we would be required to do it safely,
20 yes, I would write a prescription.

21 BY MR. OXLEY:

22 Q. Like to show you -- we talked earlier about
23 the article from ProPublica that was written that
24 involved you. Do you remember that?

25 A. I do.

1 Q. And do you know a Mary Vargas?

2 A. I do.

3 Q. Was an article that talked about her and a
4 connection with industry funding and the like also
5 published at some point?

6 A. I believe so.

7 Q. Let me have marked as Exhibit 48 an email
8 chain.

9 (Exhibit 48 marked)

10 BY MR. OXLEY:

11 Q. And this is a document that was produced by
12 you, and it bears production numbers Fish 007069
13 through 00707, and my first question is if Exhibit 48
14 is a true and correct copy of an email exchange that
15 you were a part of on February 25th and
16 February 26th, 2012.

17 A. I believe it is.

18 Q. All right. And can you tell the jury what
19 the issue was that led to this email exchange,
20 please?

21 A. I learned that there was an article titled
22 "Pharma Liars" that came out with Mary Vargas, an
23 interview Mary Vargas had done with Anderson Cooper,
24 and Mary Vargas was the vice chair and then the --
25 succeeded me as chair of the board at APF. She's an

1 attorney with chronic pain who I think publicly
2 disclosed she had a spinal cord stimulator and she
3 used opioids, and I -- you know, again, we don't have
4 the article here. I don't think the actual article
5 is here. I don't know if you have that.

6 But I think that she was slammed again as
7 someone who was painted as telling her story to
8 support the interests of pharmaceutical companies as
9 opposed to telling her story because she wanted
10 people to understand her pathway and the suffering
11 that she's endured and that people would understand
12 the treatments that she's needed to get through her
13 life and be a functional attorney.

14 Q. And in your -- so she wrote this to you, an
15 email to you talking about this, and then your
16 response to her is dated Sunday, February 26, 2012;
17 is that right?

18 A. Yeah.

19 Q. And the first thing that you say is "Mary, I
20 am all too familiar with this." Did I read that
21 right?

22 A. Yes.

23 Q. Was that a reference to what we talked about
24 before where you felt that you had been falsely
25 accused of some things based on the industry funding?

1 A. Yes.

2 Q. And then you go on to say that "I do believe
3 that the correct and just story will come out. My
4 assessment is this is akin to a witch-hunt. Andrew
5 Kolodny has become a modern-day Joe McCarthy, and he
6 and those that wish to argue his position largely as
7 a matter of attacking character and integrity rather
8 than on the merits of the issues will ultimately be
9 seen as having poor character and even less
10 integrity."

11 Did I read that correctly?

12 A. You did.

13 Q. Is that something --

14 MS. BALDWIN: Object to the form.

15 BY MR. OXLEY:

16 Q. Is that something that you believed when you
17 wrote it?

18 A. Yes.

19 Q. Do you believe it today?

20 A. Yes.

21 Q. When you referred to something that is "akin
22 to a witch-hunt," what did you mean?

23 A. I mean that there are people who have such
24 strong feelings about the harms of opioids that
25 rather than arguing about the harms of opioids, they

1 attack the character of individuals who are engaged
2 in trying to find a balance place where we can
3 balance safety and help people at the same time, and
4 they exploit the crisis by engaging a media that's
5 all too happy to tell a very bias story.

6 Q. And who is --

7 MS. BALDWIN: I'm going to object to this
8 line of questioning and several of your questions in
9 which you attempt to align plaintiffs' counsel, my
10 colleague and an expert in this case, Andrew Kolodny,
11 who you know is a disclosed expert, and I believe
12 that that's what you're doing with your line of
13 questioning.

14 To the extent you're trying to denigrate the
15 reputation of plaintiffs' expert and counsel, I
16 object to all of these questions.

17 BY MR. OXLEY:

18 Q. Who is Andrew Kolodny?

19 A. Dr. Kolodny is a psychiatrist who has had a
20 substantial role in the public discourse around the
21 excessive use of opioids and the abuse of opioids and
22 the role of pharmaceutical companies in perpetuating
23 the crisis.

24 Q. And he shares his opinions and views about
25 those issues; right?

1 A. He does.

2 MS. BALDWIN: Object to the form.

3 BY MR. OXLEY:

4 Q. You also refer to Joe McCarthy. Who was Joe
5 McCarthy? Can you please tell the jury?

6 MS. BALDWIN: Object to the form. Same
7 objection. This is an attempt to denigrate
8 plaintiffs' expert.

9 THE WITNESS: Joe McCarthy was, I believe, a
10 senator who used tactics of character assassination
11 to -- or guilt by association to assassinate the
12 character of people who were somehow associated with
13 any movement that would be assumed to be part of the
14 communist movement back in the '50's.

15 BY MR. OXLEY:

16 Q. And what ultimately happened with Joe
17 McCarthy in terms of those positions he was taking?

18 MS. BALDWIN: Object to the entire line of
19 questioning, attempting to equate Joe McCarthy to
20 Dr. Andrew Kolodny.

21 THE WITNESS: I think it was ultimately
22 found that the truth was -- that character -- that
23 guilt by association as a form of character
24 assassination to perpetuate one's ultimate goals of,
25 in his case, eradicating communism from America is

1 not a healthy ethical practice, and I think he
2 ultimately -- I don't know what happened to Senator
3 McCarthy, but we didn't hear much from him soon
4 thereafter.

5 BY MR. OXLEY:

6 Q. And when you said that Andrew Kolodny has
7 become a modern-day Joe McCarthy, what did you mean
8 by that?

9 A. Well, you know --

10 MS. BALDWIN: Objection. Same objection.

11 THE WITNESS: Again, Dr. Kolodny has very
12 strong opinions and shares those opinions. He's in
13 most of the media stories that come out on this
14 subject matter, and he has chosen -- he chose to
15 attack me personally as someone who was associated
16 with organizations that did take money from
17 pharmaceutical companies and really clearly used that
18 association to indict my character as a skill for
19 pharmaceutical companies rather than someone who was
20 trying very hard to perpetuate greater safety and
21 effective use of these drugs.

22 I would argue that Dr. Kolodny's views on
23 the use of opioids and my views are actually much
24 closer than the dialogue in the media would suggest.

25 BY MR. OXLEY:

1 Q. And what you were objecting to and
2 commenting on were not -- were really his attempts at
3 character assassination as you described it; is that
4 what you're saying?

5 MS. BALDWIN: Object to the form. Same
6 objection.

7 THE WITNESS: Right. I said here that he
8 and those that wish to argue his position largely as
9 a matter of attacking character and integrity rather
10 than the merits of the issues will ultimately be seen
11 as having poor character and less integrity, and I
12 believe that, and I actually don't think Dr. Kolodny
13 would do it the same way again had we to start this
14 whole crisis over again.

15 BY MR. OXLEY:

16 Q. You --

17 A. He's apologized, I think, even in public,
18 for some of the ways that he's gone about advocating
19 for his position.

20 Q. Did he ever apologize to you?

21 A. No.

22 Q. Did he ever apologize, to your knowledge, to
23 Ms. Vargas?

24 A. No.

25 MS. BALDWIN: Objecting to all these

1 questions.

2 MR. OXLEY: I understand. You can have a
3 continuing objection to the questions about this
4 email. I hope I'm not violating some law of the case
5 rule, but you may.

6 THE WITNESS: You know what? I should note
7 this is a personal email that was never intended to
8 be a public statement.

9 BY MR. OXLEY:

10 Q. And although it was never intended to become
11 a public statement, you wrote it -- you wrote what
12 you wrote because you believed it?

13 MS. BALDWIN: Object to form.

14 THE WITNESS: That is true.

15 BY MR. OXLEY:

16 Q. I think I'm at my time, so I will go ahead
17 and stop. Thank you very much. I very much
18 appreciate your time.

19 A. Thank you.

20 VIDEO OPERATOR: Off the record?

21 MS. BALDWIN: Can we take a break?

22 MR. ZAKRZEWSKI: Sure. Like, five minutes,
23 though.

24 MS. BALDWIN: Well, I have to go to the
25 bathroom and collect myself.

1 MR. ZAKRZEWSKI: That's fine.

2 VIDEO OPERATOR: Okay. We're off the
3 record. It's 3:59.

4 (Recess)

5 VIDEO OPERATOR: Okay. We're back on the
6 record. It's 4:19.

7 EXAMINATION

8 BY MS. BALDWIN:

9 Q. Dr. Fishman, good afternoon. We spoke
10 yesterday, and I think you mentioned earlier today in
11 your testimony that you were a respected and
12 sought-after speaker on the treatment of pain and the
13 use of opioids; would that be a fair statement?

14 MR. ZAKRZEWSKI: Objection to form.
15 You can answer.

16 MR. ERCOLE: Same objection.

17 THE WITNESS: I think I said -- and I can
18 look back and see exactly what I said, but I think
19 I've been asked to continue to present and give
20 talks, and people read my work, and they view me as a
21 respected leader.

22 BY MS. BALDWIN:

23 Q. And yesterday, we discussed the different
24 publications you've done, just generally speaking,
25 the things that you've done as a professional in your

1 line of work as medical education publications,
2 you've authored some books, you've given speeches,
3 and is is fair to say that when you engaged in those
4 activities, that they weren't -- the distribution or
5 the audience for those activities wasn't limited to
6 one specific geographical region?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: Yes.

9 BY MS. BALDWIN:

10 Q. Okay. So if you publish a book, for
11 example, as most authors would expect, you would hope
12 that your book would be published, distributed
13 broadly; is that fair to say?

14 MR. OXLEY: Objection. Improper redirect.

15 THE WITNESS: You know, I didn't really
16 think of where it would be distributed. It's
17 available, yeah.

18 BY MS. BALDWIN:

19 Q. I don't mean to talk over you.

20 When you author a book, you expect or hope
21 that people will read it; isn't that fair to say?

22 A. That's true.

23 Q. Okay. So the book that you wrote, for
24 example, Responsible Opioid Prescribing, that wasn't
25 just distributed in one specific geographical region,

1 was it?

2 MR. ERCOLE: Objection to form.

3 MR. ZAKRZEWSKI: Objection. Lacks
4 foundation.

5 You can answer if you know.

6 THE WITNESS: Well, I wrote the book for it
7 to be read, and I didn't focus on any one region.

8 BY MS. BALDWIN:

9 Q. And you wrote the book and intended that
10 book to be read by healthcare practitioners
11 throughout the country; is that fair to say?

12 MR. ZAKRZEWSKI: Objection to form,
13 foundation.

14 You can answer.

15 MR. OXLEY: I also objected that it was
16 beyond the scope of cross.

17 THE WITNESS: I could, yes.

18 BY MS. BALDWIN:

19 Q. Okay. And if the FSMB -- I represent to you
20 that the FSMB testified, and it's also in the
21 document we looked at yesterday -- the FSMB's
22 response to the U.S. Senate Finance Committee's
23 inquiry of the relations, potential conflict of
24 interest between industry and third party
25 organizations, that Responsible Opioid Prescribing

1 was distributed in the State of Oklahoma. Do you
2 have any reason to disagree with that?

3 MR. ZAKRZEWSKI: Objection to form.

4 MR. ERCOLE: Objection to form.

5 MR. ZAKRZEWSKI: Foundation.

6 THE WITNESS: No.

7 BY MS. BALDWIN:

8 Q. Okay. And is it your understanding that it
9 was the FSMB -- and when I say "FSMB," do you
10 understand that to mean Federation of State Medical
11 Boards?

12 A. I do.

13 Q. Would it be fair to say that you understood
14 that the FSMB intended to distribute that book to
15 state medical boards across the country?

16 MR. ZAKRZEWSKI: Objection. Form.
17 Foundation.

18 MR. ERCOLE: Same objection.

19 THE WITNESS: Yes.

20 BY MS. BALDWIN:

21 Q. And when you participated in a program that
22 we discussed yesterday such as, for example,
23 Janssen's program, "Let's Talk Pain," you understood
24 that that would be distributed, or the material that
25 you engaged in with respect to that activity would be

1 put on a website; is that fair to say?

2 MR. ERCOLE: Objection to form.

3 MR. ZAKRZEWSKI: Objection to form,
4 foundation, beyond the scope.

5 THE WITNESS: I honestly don't remember my
6 participation, and my suspicion is that I was asked
7 to do some -- give some interviews or talks that I'm
8 not sure where they were supposed to go.

9 BY MS. BALDWIN:

10 Q. And would it be fair to say that any
11 activities that you did with partners against pain or
12 Let's Talk Pain coalition, the audience would have
13 not been specific to one regional area in the
14 country?

15 MR. ZAKRZEWSKI: Objection. Form,
16 foundation and scope.

17 MR. ERCOLE: Same objection.

18 THE WITNESS: I don't know. I don't
19 remember, for each one of those, where it was
20 intended. I certainly don't recall it being intended
21 to be limited.

22 BY MS. BALDWIN:

23 Q. Okay. So is it fair to say that someone in
24 New York, for example, might be able to see some of
25 the material in Let's Talk Pain? Is that fair to

1 say?

2 MR. ZAKRZEWSKI: Objection. Calls for
3 speculation.

4 MR. ERCOLE: Same objections.

5 THE WITNESS: Yeah.

6 BY MS. BALDWIN:

7 Q. And that wouldn't be any different for
8 Oklahoma either, would it?

9 MR. ZAKRZEWSKI: Objection.

10 MR. ERCOLE: Same objection.

11 THE WITNESS: I suspect so. I don't know.

12 BY MS. BALDWIN:

13 Q. Okay. And when you publish an article
14 related to the treatment of pain or the use of
15 opioids, is it fair to say that that article may be
16 read by healthcare practitioners or researchers or
17 any individual in the country or even outside the
18 country?

19 A. Quite possible.

20 MR. ZAKRZEWSKI: Objection. Form,
21 foundation. Scope.

22 Go.

23 MR. ERCOLE: Same objection.

24 THE WITNESS: Quite possibly.

25 BY MS. BALDWIN:

1 Q. And is it fair to say that if you give a
2 presentation or a speech at the symposia or
3 specifically, for example, the American Academy of
4 Pain Medicine, that there's people in the audience
5 that may be from diverse geographical areas?

6 A. Yes.

7 Q. Okay. And there could be members of the APN
8 from the State of Oklahoma; is that possible?

9 MR. ZAKRZEWSKI: Objection.

10 MR. ERCOLE: Same objection.

11 MR. OXLEY: Objection. Also, we really are
12 beyond the scope of what was asked and --

13 MS. BALDWIN: Disagree. There was --
14 disagree.

15 MR. OXLEY: I'm not talking to you right
16 now, but thank you.

17 MS. BALDWIN: Oh.

18 MR. OXLEY: And so I feel like there's a lot
19 more that I could ask and cut myself off to fit the
20 time limits that we agreed on, and I just don't think
21 it's right to be able to go through things that are
22 not redirect.

23 MS. BALDWIN: I'm not going to respond to
24 that. Three different defendants asked questions,
25 and there was a specific line of questioning about

1 what was exposed to the State of Oklahoma. This is
2 absolutely within the scope of their examination.

3 MR. ZAKRZEWSKI: I'm not a judge.

4 MS. BALDWIN: So I'm just -- sorry if you
5 don't like my questions, but I'm going to keep asking
6 them.

7 MR. OXLEY: It's the content of your
8 questions.

9 BY MS. BALDWIN:

10 Q. Is it fair to say that the organizations,
11 professional organizations that you're a member of
12 and other -- not just you but other physicians or
13 healthcare providers are a member of, that there may
14 be members from the State of Oklahoma? Is that fair
15 to say?

16 MR. ZAKRZEWSKI: Objection. Form,
17 foundation, scope.

18 But, I mean, you can answer with respect to
19 your personal knowledge.

20 MR. OXLEY: Join.

21 MR. ERCOLE: Same objection.

22 THE WITNESS: I mean you're asking me if
23 they might have members? Yes, they might. I have no
24 idea if they do or not.

25 BY MS. BALDWIN:

1 Q. And if an individual, a key opinion leader
2 or a speaker gives a speech at an event held or
3 sponsored by the American Academy of Pain Medicine or
4 the American Pain Foundation or the American Pain
5 Society, that material may be distributed to
6 individuals outside of wherever that conference is
7 held; is that fair to say?

8 MR. ZAKRZEWSKI: Same objection.

9 You can answer on personal knowledge.

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: Wouldn't be impossible. I
12 have no idea if it really happens, but --

13 BY MS. BALDWIN:

14 Q. And we saw yesterday that the American Pain
15 Foundation was involved in various advocacy
16 activities; correct?

17 A. Yes.

18 Q. Okay. And one of the documents that we
19 discussed indicated that some of those advocacy
20 activities took place in Oklahoma. Do you recall
21 that?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: Oklahoma is listed on the
24 pages that you showed me.

25 BY MS. BALDWIN:

1 Q. And when the American Pain Foundation
2 created materials, any materials, and with the
3 purpose of carrying out their various agenda, those
4 materials were distributed broadly; is that fair to
5 say?

6 MR. ERCOLE: Objection to form.

7 MR. ZAKRZEWSKI: Objection. Same objection.

8 THE WITNESS: I don't know.

9 BY MS. BALDWIN:

10 Q. Well, you said the American Pain Foundation,
11 I believe, was a foundation for patients. Is that to
12 address --

13 A. Consumers.

14 Q. And consumers. Is that fair to say?

15 A. Uh-huh.

16 Q. And patients and consumers -- that event
17 that organization was seeking to address was not
18 limited to one specific geographic area?

19 A. It was not.

20 Q. Okay. So someone in California could have
21 read materials that were created and distributed by
22 the American Pain Foundation?

23 MR. ERCOLE: Objection to form. Foundation.

24 MR. ZAKRZEWSKI: Objection to form.

25 THE WITNESS: Correct.

1 BY MS. BALDWIN:

2 Q. Okay. And these questions, I've asked some
3 specifically with respect to work you've done or with
4 respect to work these -- the APF or APM or APS have
5 done, but would that be fair to say for publications
6 that another physician has written regarding chronic
7 pain management or the use of opioids?

8 MR. ERCOLE: Objection to form. Foundation.

9 MR. ZAKRZEWSKI: Objection to form.

10 THE WITNESS: I don't know how to answer
11 that. It depends. People have written things that,
12 you know, they've written them, but they didn't do
13 anything with them, they've had limited distribution,
14 they've had wide distribution. It really depends.

15 BY MS. BALDWIN:

16 Q. Fair enough. I have a few questions about
17 Exhibit 32. This Settlement Agreement that you
18 talked about earlier, you understand that the State
19 of Oklahoma is not a party to this Settlement
20 Agreement?

21 A. I do.

22 Q. Okay. And you understand that during that
23 line of questioning about this Settlement Agreement,
24 that any statements that referred to plaintiffs'
25 counsel referred to only the plaintiffs' counsel

1 involved in the litigation specifically referenced in
2 this Settlement Agreement; correct?

3 A. I do.

4 MR. ZAKRZEWSKI: Objection. Form.

5 THE WITNESS: And don't reflect the
6 plaintiffs' attorneys here in this room.

7 BY MS. BALDWIN:

8 Q. Okay.

9 MR. ZAKRZEWSKI: Wait a minute.

10 Can you read back the question?

11 (Record read as follows: "And you
12 understand that during that line of
13 questioning about this Settlement Agreement,
14 that any statements that referred to
15 plaintiffs' counsel referred to only the
16 plaintiffs' counsel involved in the
17 litigation specifically referenced in this
18 Settlement Agreement; correct?")

19 MR. ZAKRZEWSKI: I don't recall him
20 testifying about any plaintiffs' counsel other than
21 the fact that they are the plaintiffs' counsel that
22 are party to that agreement.

23 MS. BALDWIN: That was not my question. My
24 question was when the drug company attorneys were
25 referring to plaintiffs' counsel, when they were

1 referencing Exhibit 32, that they were referring to
2 the attorneys representing the plaintiffs
3 specifically referred in that Settlement Agreement.

4 MR. ZAKRZEWSKI: Fine. As long as we're
5 not --

6 MR. ERCOLE: Objection to form.

7 MR. ZAKRZEWSKI: That's fine. As long as
8 we're attributing the question to who the agreement
9 was with, that's fine. He's made no comment about
10 any lawyers.

11 THE WITNESS: That was my understanding.

12 BY MS. BALDWIN:

13 Q. Okay. And any comments made by the drug
14 company attorneys about the plaintiffs in relation to
15 discussing this Settlement Agreement concerned only
16 those plaintiffs that are specifically referenced in
17 that Settlement Agreement; is that fair to say?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: Yes.

20 BY MS. BALDWIN:

21 Q. And, again, the State of Oklahoma is not a
22 plaintiff that is a party to this Settlement
23 Agreement?

24 MR. OXLEY: Objection. Form, asked and
25 answered.

1 BY MS. BALDWIN:

2 Q. Do you understand that?

3 A. Yes.

4 Q. You understand that the plaintiff the State
5 of Oklahoma had absolutely nothing to do with the
6 creation or execution of this Settlement Agreement?

7 MR. OXLEY: Objection. Form.

8 THE WITNESS: I do.

9 BY MS. BALDWIN:

10 Q. And you understand that the State of
11 Oklahoma is not bound by this Settlement Agreement?

12 A. I don't know why I would think it would.

13 Q. Now this Settlement Agreement references --
14 I don't know the exact number. There's a lot of
15 litigation listed here. So is it fair to say over a
16 hundred lawsuits?

17 MR. ZAKRZEWSKI: Objection.

18 If you know.

19 THE WITNESS: I don't know. I think it's
20 more than a hundred.

21 BY MS. BALDWIN:

22 Q. More than a hundred? And is there other --
23 there is other litigation throughout the country in
24 which you are named as a defendant; is that correct?

25 A. Other than listed there?

1 Q. Yes.

2 A. Yeah. Not many, but some.

3 Q. Okay.

4 A. Is that fair?

5 Q. Do you know the names of those cases?

6 A. I don't.

7 Q. Okay. And in those cases where you are --
8 you are named as a defendant not covered by the
9 Settlement Agreement, are there other defendants in
10 that litigation as well?

11 MR. ZAKRZEWSKI: Objection.

12 You can answer these questions to the extent
13 you actually know and have personal knowledge. Do
14 not answer anything that you've learned from your
15 discussions with counsel.

16 THE WITNESS: Yeah. No, I don't know. I
17 don't keep -- there have been so many, I don't keep
18 track of them.

19 BY MS. BALDWIN:

20 Q. Do you know if Purdue is a defendant in any
21 of the litigations in which you have been named as a
22 defendant?

23 A. Again, Purdue seems to be a defendant in all
24 the cases, so I suspect so, but I don't know
25 specifically.

1 Q. And is Johnson & Johnson and Janssen a
2 defendant in any of the lawsuits in which you are a
3 defendant?

4 MR. ZAKRZEWSKI: Same objection.

5 Whatever you recall from your personal
6 knowledge.

7 THE WITNESS: I don't know specifically.

8 BY MS. BALDWIN:

9 Q. Do you know if Cephalon's a defendant in any
10 of the lawsuits in which you've been named as a
11 defendant?

12 MR. ZAKRZEWSKI: Same objection.

13 MR. ERCOLE: Objection to form.

14 MR. ZAKRZEWSKI: Answer only with respect to
15 personal knowledge, not from communications with
16 counsel.

17 THE WITNESS: I don't know.

18 BY MS. BALDWIN:

19 Q. You're aware that other opioid manufacturers
20 are named as defendants --

21 A. Yes.

22 Q. -- in lawsuits in which you are also named
23 as a defendant?

24 A. Yes.

25 Q. Do you understand that?

1 MR. ZAKRZEWSKI: Pushing 15 minutes here,
2 so --

3 BY MS. BALDWIN:

4 Q. Do you know who coined the term
5 "pseudoaddiction," Dr. Fishman?

6 A. You know, it's attributed to -- in my
7 memory, to Dr. Joan Dahl and Dr. David Haddox.

8 Q. Okay. And Dr. Haddox was an executive at
9 Purdue Pharma?

10 MR. ZAKRZEWSKI: Objection. Form and
11 foundation.

12 You mean at the time of pseudoaddiction or
13 later?

14 MS. BALDWIN: Fair question. I'll rephrase
15 my question.

16 BY MS. BALDWIN:

17 Q. David Haddox was, for many years, an
18 executive at Purdue Pharma; is that fair to say?

19 MR. ZAKRZEWSKI: Objection.

20 You can answer.

21 THE WITNESS: Yes.

22 BY MS. BALDWIN:

23 Q. Okay.

24 A. He was a practicing pain physician at the
25 time that he worked on that concept.

1 Q. Did you know that he was also a member of
2 Purdue Speakers Bureau when he coined that term?

3 A. I did not.

4 Q. But did you know he was an executive of
5 Purdue Pharma for a long period of time?

6 A. Yes.

7 MR. OXLEY: Objection. Vague as to time.

8 BY MS. BALDWIN:

9 Q. And he also -- David Haddox also did a
10 line-by-line edit of Responsible Opioid --

11 MR. ZAKRZEWSKI: Objection.

12 So now you're going back into something you
13 questioned him in detail about yesterday, and that
14 was specifically asked and answered. He explained
15 that he had no idea about line-by-line.

16 MS. BALDWIN: Can you just state your
17 objection? I'm wrapping up here. Can you just state
18 your objection?

19 MR. ZAKRZEWSKI: I mean my objection is
20 shortly going to be we're done if we're going to go
21 back over stuff that you covered.

22 BY MS. BALDWIN:

23 Q. And the David Haddox that coined the term
24 "pseudoaddiction" is the same David Haddox that did a
25 line-by-line edit of the possible opioid document; is

1 that true?

2 MR. ZAKRZEWSKI: Same objection.

3 Argumentative.

4 MR. EHSAN: Same objection.

5 THE WITNESS: I saw the words "line-by-line"
6 on paper. I don't really know what that means. He
7 did some editing of the book, and I had asked him
8 some questions, and he basically came back with
9 grammatical changes as I recall.

10 BY MS. BALDWIN:

11 Q. Okay. And I recall you saying that you
12 couldn't recall whether or not he made any
13 substantive changes.

14 MR. ZAKRZEWSKI: Objection. Form.

15 MR. ERCOLE: Objection.

16 THE WITNESS: What I recall is he said he
17 made grammatical changes and not substantive ones,
18 but I don't recall. It was a long time ago.

19 BY MS. BALDWIN:

20 Q. So you can't recall?

21 MR. ZAKRZEWSKI: Objection.

22 MR. OXLEY: Objection. Asked and answered.

23 THE WITNESS: I don't recall what I said.

24 BY MS. BALDWIN:

25 Q. And did David Haddox review the section on

1 pseudoad addiction in Responsible Opioid Prescribing?

2 A. I don't recall. I suspect he did. I don't
3 know that he commented on it.

4 Q. Well, if he reviewed the entire book, it's
5 fair to say that he reviewed every section of the
6 book?

7 MR. ERCOLE: Objection to form.

8 MR. ZAKRZEWSKI: Objection. Asked and
9 answered, form, foundation.

10 THE WITNESS: I doubt that he commented on
11 it.

12 BY MS. BALDWIN:

13 Q. You said you don't recall, but you doubt?

14 A. Well, I -- simply by fact, I think I would
15 recall had he made those kinds of comments, and my
16 vague recollection is that he commented on very
17 little other than grammar.

18 Q. Okay. But you don't know for sure?

19 A. I don't.

20 Q. And he suggested or he informed in the
21 incident report that we looked at yesterday that he
22 had done a line-by-line edit; correct?

23 MR. ZAKRZEWSKI: Objection. Form,
24 foundation. Asked and answered four times.

25 We're done.

1 BY MS. BALDWIN:

2 Q. Correct?

3 A. Yes.

4 Q. Okay. Pass the witness.

5 EXAMINATION

6 BY MR. OXLEY:

7 Q. Dr. Fishman, I'd just like to hand you -- or
8 have the court reporter mark and hand you a document
9 that we'll have marked as Exhibit 49.

10 (Exhibit 49 marked)

11 BY MR. OXLEY:

12 Q. And I'll represent to you that this is a
13 document that was used as an exhibit that counsel
14 should have from Dr. Haddox's deposition, and my
15 question to you is just does Exhibit 49 reflect the
16 email from Dr. Haddox and the comments that
17 Dr. Haddox made on the Responsible Prescribing of
18 Opioids book that you drafted?

19 A. (Moves head up and down).

20 Q. Yes?

21 A. Are you asking me is that what I have in
22 hand?

23 Q. Yes.

24 A. Yes, it is.

25 Q. You were asked some questions about

1 pseudoaddiction, and I think you said that Dr. Haddox
2 and another academic wrote a paper that talked about
3 pseudoaddiction; right?

4 A. I believe so.

5 Q. And who was that other author?

6 A. I think it was Dr. June Dahl.

7 Q. At the time, was that paper published in the
8 peer review literature?

9 MS. BALDWIN: Object to form.

10 THE WITNESS: I believe so. They were both
11 at the University -- or the Wisconsin Medical
12 College. They were in academic practice.

13 BY MR. OXLEY:

14 Q. And do you know when that was published?

15 A. I don't. I would estimate it was late
16 '90's, somewhere around there.

17 Q. Okay. You were asked some followup
18 questions about the Settlement Agreement that you
19 entered into and the more than a hundred lawsuits
20 that had been filed against you. What impact would
21 it have had on you personally if you had continued to
22 litigate those cases as opposed to settling them?

23 MS. BALDWIN: Object to form.

24 MR. ZAKRZEWSKI: Objection.

25 THE WITNESS: Can I answer?

1 MR. ZAKRZEWSKI: You can answer.

2 THE WITNESS: Again, it's reputational
3 assassination. They're perpetuating charges against
4 me that they don't have to -- not a single case has
5 had to actually support with any facts. It's
6 incredible, you know, financial stress. It's a
7 stress on my time. It takes me away from my
8 professional work, my family. It's emotionally
9 disturbing, you know. It's been like getting a bad
10 virus and, you know, losing your hair and all that.

11 BY MR. OXLEY:

12 Q. Well, some of us lost our hair naturally, so
13 it wasn't from a virus, unfortunately. Or maybe
14 fortunately.

15 And, doctor, in the settlement that you
16 entered into with those plaintiffs who had made all
17 those allegations against you in more than a hundred
18 cases, the resolution was basically they said, "Case
19 dismissed"; right?

20 MS. BALDWIN: Object to form.

21 THE WITNESS: That's correct. And I should
22 add, if I can fill that out, that what I agreed to
23 was that I would continue to tell the truth and that
24 I'd be happy to have them ask me more questions under
25 oath as a witness for a circumscribed period of time,

1 that I would make myself available to continue to
2 simply tell the truth. I didn't agree to really
3 anything else other than simply to be available to
4 continue to tell them the truth as I know it.

5 BY MR. OXLEY:

6 Q. And in the research and the publications
7 that you have devoted your life to since you began
8 pain medicine, working in the field of pain medicine,
9 is that something that you always strive to do, to
10 tell the truth and to tell things the way they were
11 and the way that you believed them at the time you
12 published your papers or gave your presentations?

13 MS. BALDWIN: Object to form and leading.

14 THE WITNESS: I do.

15 BY MR. OXLEY:

16 Q. You saw some documents yesterday that showed
17 what the plaintiff in this case was saying were
18 payments that were made to you by different
19 pharmaceutical companies. Do you remember that? Do
20 you remember looking at that document?

21 A. Yes.

22 Q. Is there any amount of money that could have
23 been paid to you to get you to lie?

24 A. That's good question.

25 MS. BALDWIN: Object to form.

1 THE WITNESS: I think the answer is no. I
2 make a good salary. I support my family. If I
3 wanted to make more money, I would simply get a
4 different job.

5 BY MR. OXLEY:

6 Q. Thank you, doctor.

7 A. Thank you. Done?

8 MR. EHSAN: Read and sign?

9 MR. ZAKRZEWSKI: Yes. We're done.

10 VIDEO OPERATOR: We're off the record. It's
11 4:44.

12 THE REPORTER: Do you want a rough or copy?

13 MR. ZAKRZEWSKI: We don't need a rough.

14 THE REPORTER: Just a copy?

15 MR. ZAKRZEWSKI: Yeah. We've got to read
16 and sign.

17 THE REPORTER: Mr. Oxley, do you want a
18 rough too?

19 MR. OXLEY: Yes.

20 THE REPORTER: And, Brian, you want a rough?

21 MR. ERCOLE: Yes. Thank you.

22 MS. BALDWIN: I want a rough.

23 MR. EHSAN: I would like a rough and a copy.
24 It's not in the standing order, but I want a rough
25 anyway.

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ACKNOWLEDGMENT OF DEPONENT

I, SCOTT FISHMAN, M.D., do hereby certify
that I have read the foregoing transcript of my
testimony taken on 2/27/19, and further certify
that it is a true and accurate record of my
testimony (with the exception of the corrections
listed below):

Page	Line	Correction
_____	_____	_____
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SCOTT FISHMAN, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME
THIS _____ DAY OF _____, 20____.

(NOTARY PUBLIC) MY COMMISSION EXPIRES: _____

1 I, the undersigned, a Certified Shorthand
2 Reporter of the State of California, do hereby
3 certify:

4 That the foregoing proceedings were taken
5 before me at the time and place herein set forth;
6 that any witnesses in the foregoing proceedings,
7 prior to testifying, were duly sworn; that a record
8 of the proceedings was made by me using machine
9 shorthand which was thereafter transcribed under my
10 direction; that the foregoing transcript is a true
11 record of the testimony given.

12 Further, that if the foregoing pertains to
13 the original transcript of a deposition in a Federal
14 Case, before completion of the proceedings, review of
15 the transcript [] was [] was not requested.

16 I further certify I am neither financially
17 interested in the action nor a relative or employee
18 of any attorney or party to this action.

19 IN WITNESS WHEREOF, I have this date
20 subscribed my name.

21
22 Dated: March 6, 2019

23 
24

CARRIE PEDERSON

25 CSR No. 4373

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Oklahoma
Rule 12-3230
Depositions Upon Oral Examination

F. Review By Witness; Changes; Signing.

The deponent shall have the opportunity to review the transcript of the deposition unless such examination and reading are waived by the deponent and by the parties. After being notified by the officer that the transcript is available, the deponent shall have thirty (30) days in which to review it and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by paragraph 1 of subsection G of this section whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.